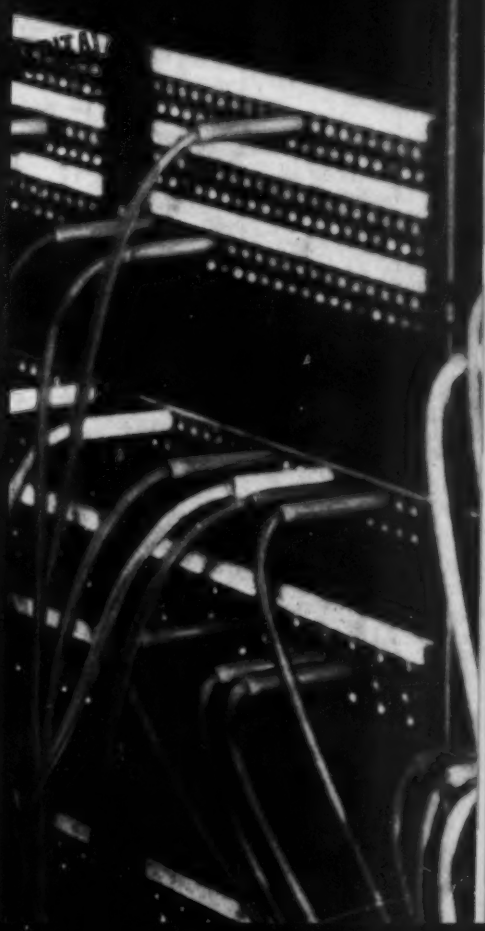
Medical Economics

PUBLISHED EVERY OTHER MONDAY • ISSUE OF APRIL 27, 1959

How Good Is Your After-Hours Coverage?



fast

welcome relief of spasm and pain is continuously reported in functional G-I disorders, such as irritable, spastic colon syndrome; peptic ulcer; biliary dyskinesia; pylorospasm; and infant colic.

sure

relief can be expected . . . even in patients where other antispasmodics have failed.[1-4]

direct

dual antispasmodic action is specific to the G-I tract. Spasm pain is relieved by direct relaxation of the smooth muscle and postganglionic parasympathetic nerve blockage.

safe

even in the presence of glaucoma[1] *. . . BENTYL does not increase intraocular tension, produce blurred vision, dry mouth or urinary retention.*

relief of g-i spasm & pain

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20 mg. t.i.d. (dicyclomine) Hydrochloride

1. Chamberlain, D. T.: Gastroenterology *17*:224, 1951. 2. Hock, C. W.: J. M. A. Ga. *42*:124, 1951. 3. Derome L.: Canad. M. A. J. *69*:532, 1953. 4. Cholst, M., Goodstein, S., Berens, C., and Cinotti, A.: J. A. M. A. *166*:1276, 1958.

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Medical Economics

NEWS BRIEFS

INSURE YOUR INSURABILITY? You can if you get one of the new life insurance policies that guarantee your right to buy more insurance later on. Some 20 firms now offer them, and many M.D.s are buying them for themselves or their children.

NUMBER OF M.D.s WHO'RE HOSPITAL-EMPLOYED specialists or administrators has jumped from 10,999 to 13,581 in the last 2 years, A.M.A. figures show.

MALPRACTICE CLAIMS ARE NOW COSTING doctors and hospitals around $45,000,000 per year, according to Actuarial Expert Joseph Linder of New York. This estimate includes the cost of court judgments, out-of-court settlements, investigation expenses, and legal fees.

IF YOU FIND YOU MADE A MISTAKE in your Federal income tax return for '58, you can still correct it, tax men point out. Simply file an amended return with the correct information.

NEWS BRIEFS

AIRLINE STOCKS HAVE A BRIGHTER FUTURE NOW than they've had in many years, some investment men believe. Key reason: Use of the new jets has raised average passenger loads 50% or more; may increase total passenger travel 100% by 1965.

DESPITE DOCTORS' OPPOSITION, a second state now has a law requiring blood for transfusions to be labeled with the donor's race. Louisiana passed the first such law last year. Now Arkansas has followed suit. "There was a great demand by the public" for this law, says Gov. Orval E. Faubus.

NEW BLAST BY G.P.s at the report on closed-panel medicine issued by the A.M.A.'s Commission on Medical Care Plans may spark some hot debate at the A.M.A. meeting in June. The A.A.G.P. charges that the report "contains much double talk...It espouses the cause of the closed-panel plans... [yet] admits that 'America has reached its medical greatness' through private practice."

WHO'S LEGALLY RESPONSIBLE for a baby's care after delivery? The delivering physician is until another doctor actually takes over, says Texas Medical Association Counsel Philip R. Overton. Even in an emergency delivery, he warns, you must care for the child until the regular physician arrives—or risk an abandonment claim.

MAJOR SPECIALTIES that have the lowest percentage of board-certified men, A.M.A. figures show, are now internal medicine (53%) and OB/Gyn. (54%).

CUT-RATE BLUE SHIELD CONTRACT for the aged isn't popular with some doctors in the first state to adopt it. The Union County (Iowa) Medical Society has sent all Iowa M.D.s a letter asking: "Is it proper...that medicine should be forever asked to solve [the aged's health problems] by reduction of its fees?...Are we to continue... to accept less and less for these services?... We cannot continue this delusion much longer."

M.D.s' MEDIAN FEES FOR INITIAL OFFICE VISITS, a new survey by this magazine shows, are as follows: G.P.s, $4; surgeons and pediatricians, $5; internists and OB/Gyn. men, $10.

WHO'S BEHIND THE MALPRACTICE PROBLEM today? A relatively few "suit-happy patients and... suit-inviting doctors," says a new Saturday Evening Post malpractice series. "If they could be isolated someplace and allowed to assail each other with lawsuits, lost sponges, or whatever weapons came to hand," there'd be no problem. But instead, "with a power to cause damage far out of proportion to their small numbers, they have raised havoc among all doctors and all patients."

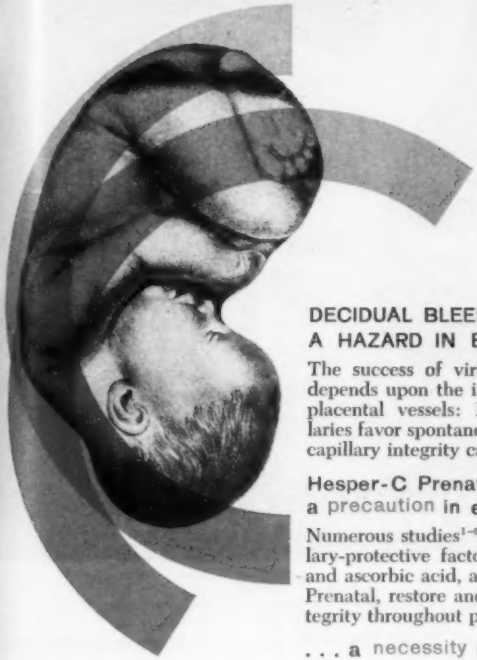
NEWS BRIEFS

BILL TO SUSPEND THE LICENSE of any M.D. who gets treatment for mental illness in New York has been tabled. N.Y. doctors opposed the bill strongly. Now Attorney General Louis Lefkowitz, the bill's chief backer, says it needs "further study."

PLAINTIFFS' ATTORNEYS CAN'T GO FISHING through hospital records in South Dakota now. At the urging of the South Dakota Medical Society, the state legislature has passed a law that bans using tissue committee reports or other data procured by hospital staff studies as evidence in court.

WALL STREET IS TRYING TO PUT A DAMPER on speculating in stocks. The New York Stock Exchange has asked all members to curb "reckless speculation by the uninformed." And the Securities and Exchange Commission warns that stock prices are fluctuating "unduly" now, "often as a result of baseless tips and rumors." It adds: "The amateur who 'plays the market' is asking for trouble."

DOES ALASKA NEED M.D.s OR NOT? Dr. W. M. Whitehead, president of Alaska's medical society, says "we have just about enough doctors." But newly elected Alaskan Senator Dr. Ernest Gruening recently told New York medical men his state has so severe a shortage of doctors that many Alaskans "live and die without benefit of therapy."



DECIDUAL BLEEDING . . . A HAZARD IN EVERY PREGNANCY

The success of virtually every pregnancy depends upon the integrity of the mother's placental vessels: Fragile decidual capillaries favor spontaneous abortion;[1,2] restored capillary integrity can prevent it.

Hesper-C Prenatal . . . a precaution in every pregnancy

Numerous studies[1-6] confirm that the capillary-protective factors, hesperidin complex and ascorbic acid, as provided in Hesper-C Prenatal, restore and maintain capillary integrity throughout pregnancy.

. . . a necessity in habitual abortion

In habitual aborters, the administration of hesperidin complex and ascorbic acid results in impressive fetal salvage—as high as 95% in one Hesper-C series.[4] "Repeat performances" often follow.

Hesper-C Prenatal

capillary-protective factors + vitamins and minerals

References: **1.** Greenblatt, R. B.: Obst. & Gynec. 2:530, 1953. **2.** Pearse, H. A., and Trisler, J. D.: Clin. Med. 4:1081, 1957. **3.** Javert, C. T.: Spontaneous and Habitual Abortion, New York, The Blakiston Division, McGraw-Hill Book Co., Inc., 1957, p. 338 ff. **4.** Javert, C. T.: Obst. & Gynec. 3:420, 1954. **5.** Dill, L. V.: M. Ann. District of Columbia 23:667, 1954. **6.** Greenblatt, R. B.: Ann. New York Acad. Sc. *61*:713, 1955.

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Mucotin promotes *natural* healing two ways:

PHYSICALLY natural gastric mucin in Mucotin promptly spreads a protective coat over raw or inflamed mucosa—creates an acid-barrier action against further gastric enzyme damage.

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Mucotin is a soothing adjunct to any peptic ulcer regimen and assures prompt relief in hyperacidity, chronic gastritis, pylorospasm, and gastroenteritis. Dosage: two pleasant-tasting tablets 2 hours after each meal or whenever symptoms are pronounced.

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Each Mucotin tablet contains: *natural gastric mucin 160 mg. (2½ gr.)*
aluminum hydroxide gel 250 mg. (4 gr.)
Magnesium trisilicate 450 mg. (7 gr.)

Medical Economics

INDEPENDENT NATIONAL BUSINESS MAGAZINE FOR PHYSICIANS, APRIL 27, 1959

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Holes in Your Life Insurance Program? ***69***

Take a few minutes to ask yourself these eight questions. They may help you spot weaknesses in your program that could cause you and your family plenty of grief

Don't Overlook Convertible Bonds ***73***

These two-way securities offer the safety of regular bonds plus the growth potential of common stocks—if you pick good ones. But what are 'good' ones? Here's the answer

Showing the Patient What He's Paying For ***78***

The steps by which you can convey fee information to your aide and to your patients are illustrated in detail here

How Good Is Your After-Hours Coverage? ***82***

Here's what can go wrong when you're out of touch with your patients for a few hours or a week-end. Here, too, are some tips on how to keep covering arrangements trouble-free

More▶

 Published fortnightly at Oradell, N. J. Vol. 36, No. 9. Price 60 cents a copy, $12.50 a year (Canada and foreign, $15). Circulation, 153,000 physicians. Address all editorial and business correspondence to MEDICAL ECONOMICS, Oradell, N. J.

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12 significant vitamins and minerals

Natalins® Basic

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two formulations to meet individual needs of your patients

The need of the multipara for supplemental nutrition may be greater as successive pregnancies deplete her stores of nutrients. Anemia has been found to occur more frequently in multiparas than in primigravidas[1]—

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1. Traylor, I. D., and Torpin, R.: Am. J. Obst. & Gynec. 61: 71-74 (Jan.) 1951.

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They're Exposing Plaintiffs' Attorneys' Tricks 87

Defense counsel have discovered new ways to combat the use of gruesome medical photos, blackboard computation of damages, and other tactics used against doctors in court

Tax Benefits of Office-Building Ownership 91

You can save money when you buy the property, every year you own it, and even when you sell it. Here are direct answers to the questions you may be wondering about

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Financial experts say most $1-to-$15 shares are best left alone. How do you spot the ones that stand up as interesting investments? First you find the facts behind their bargain-basement price tags. Start with these pointers

How I Lost Patients—and Then Won Them Back . . 113

Excessive formality with patients doesn't pay, but friendliness does, this young doctor has found. And to prove his point, he cites a unique and tragic experience

How to Satisfy Your Urge to Do Research 125

It makes exciting, rewarding spare-time work. But the obstacles are formidable for any physician in private practice. Listen to what these doctors have to say ***More▶***

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Lawsuit Situation: What Would You Do? ***147***

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It's sure to boost your expenses, but it may very well boost your net earnings even more, this report indicates

They're Taking a 60% Cut in Fees ***167***

These doctors are first on the market with a new kind of Blue Shield contract. It's designed to provide medical care for people over 65 whose resources are limited

How to Collect From an Estate ***176***

Are you writing off deceased patients' bills because collecting them seems more trouble than it's worth? It isn't too difficult, usually. Here's the way to go about it

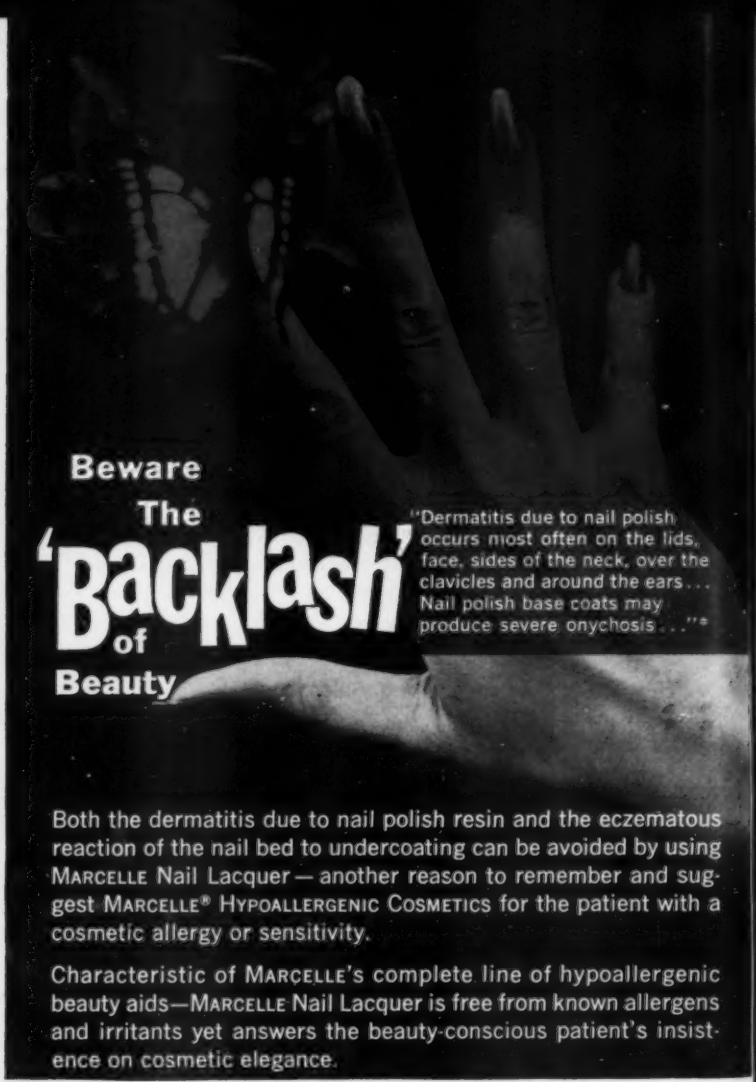
Injections Without Tears: Kids Go for This Game . . ***188***

Are crying children a problem in your office? A pediatrician tells you how to keep them quiet and—almost—happy

'Doctors Can't Beat the Forand Bill' ***199***

Medicine's current efforts to lower fees for the aged won't do any good; in fact, they'll do plenty of harm, argues this physician. Here he points out why

More▶



Beware The 'Backlash' of Beauty

"Dermatitis due to nail polish occurs most often on the lids, face, sides of the neck, over the clavicles and around the ears... Nail polish base coats may produce severe onychosis..."*

Both the dermatitis due to nail polish resin and the eczematous reaction of the nail bed to undercoating can be avoided by using MARCELLE Nail Lacquer—another reason to remember and suggest MARCELLE® HYPOALLERGENIC COSMETICS for the patient with a cosmetic allergy or sensitivity.

Characteristic of MARCELLE's complete line of hypoallergenic beauty aids—MARCELLE Nail Lacquer is free from known allergens and irritants yet answers the beauty-conscious patient's insistence on cosmetic elegance.

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*Andrews, G.,C.: Diseases of the Skin, ed. 4, Philadelphia, Saunders, 1954, pp. 117, 118.

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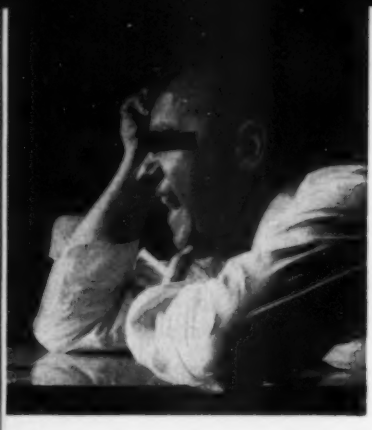

in alcoholism[1,2]

ACUTE EMERGENCIES — a single intramuscular injection of 50 mg. (2 cc.) Vistaril Parenteral Solution is usually sufficient to calm the patient and initiate sound sleep. Vistaril is exceptionally well tolerated. Antiemetic action and absence of respiratory depression are among valuable assets reported.

REHABILITATION—oral administration of 100-400 mg. daily in divided doses provides psychotherapeutic action which maintains calm and confidence, and promotes anxiety-free abstinence. The remarkable safety of Vistaril is reassuring in long-term maintenance.

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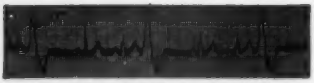

1. Premature Ventricular Contractions

2. Paroxysmal Auricular Tachycardia

3. Paroxysmal Ventricular Tachycardia

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REFERENCES: 1. Miller, R. F.: Clinical Review, Vol. 1, No. 2 (July) 1958. 2. Van Gasse, J. J.: Clinical Medicine, 5:177-181 (Feb.) 1958. 3. Burrell, Z. L., et al.: Am. J. Cardiol., 1:624 (May) 1958. 4. Hutcheon, D. E., et al.: J. Pharmacol. & Exper. Therap., 118:451 (Dec.) 1956.

in arrhythmias[3,4]

Many types of cardiac arrhythmias respond promptly to oral, intramuscular or intravenous Vistaril therapy. Vistaril is particularly effective in ventricular extrasystoles, paroxysmal tachycardias (both auricular and ventricular), and ventricular extrasystoles complicating auricular fibrillation. The following dosage regimen is recommended:

PARENTERAL DOSAGE: 50-100 mg. (2-4 cc.) I.M. stat., and q. 4-6 h. p.r.n.; maintain with 25 mg. b.i.d. or t.i.d.

IN ACUTE EMERGENCY, 50-75 mg. (2-3 cc.) I.V. stat.; maintain with 25-50 mg. (1-2 cc.) I.V. q. 4-6 h. p.r.n.

ORAL DOSAGE: Initially, 100 mg. daily in divided doses until arrhythmia disappears. For maintenance or prophylaxis, 50-75 mg. daily in divided doses.

SUPPLY: *Vistaril Capsules, 25 mg., 50 mg. and 100 mg. Vistaril Parenteral Solution, 10 cc. vials, and 2 cc. Steraject® Cartridges, each cc. containing 25 mg. hydroxyzine hydrochloride.*

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A CIBA Documentary Report

How clinicians evaluate the safety and effectiveness of RITALIN® as a psychic stimulant

CONDITIONS TREATED	RESULTS	COMMENTS ON SAFETY
Depression accompanying chronic illness and convalescence from short-term illness; mild depression induced by life pressures; overtranquilization.	"The drug gave a plateau type of stimulation, smooth onset, with no euphoria . . . The effect lasted about four hours, gave the patient a feeling of well-being . . ."	"The side effects of Ritalin are minimal." "The work showed that the drug had no effect on blood pressure, the blood count, urine or blood sugar, did not depress the appetite, and produced no tachycardia."[1]
Lethargy, fatigue and emotional depression secondary to chronic illness in elderly patients; mild depression secondary to short-term illness. (Twenty-three "normal," healthy people also received the drug.)	"For the entire 112 patients 66 per cent showed marked improvements [obvious drug effect and mood improvement] . . ."	"No serious side reactions were noted . . . In no case was it necessary to stop the drug. No evidence of significant effect upon blood pressure or pulse has been found. This is particularly interesting, since these side effects have been common with other mood elevating drugs . . ."[2]
Drug-induced psychophysiologic depression; physiologic after-effects of certain anesthetics; barbiturate intoxication; moribund states due to systemic infection. (All patients were epileptic, mentally retarded and/or brain damaged.)	"All except two [of 129] patients responded to the initial injection [of parenteral Ritalin] within 1½ to 15 minutes."	"In no instance was there any evidence of untoward effects." "... the very poor basic physical condition of our patients in this study, those associated with profound chronic brain damage, accentuates the safety of parenteral Ritalin . . ."[3]

DOSAGE: *Oral:* Dosage will depend upon indication and individual response. Many patients respond to 10 mg. b.i.d. or t.i.d. Others will require 20-mg. doses. In a few cases, 5-mg. doses will be adequate. If inability to sleep is encountered, last dose should be given before 6 p.m. *Parenteral:* 10 to 30 mg., intravenously or intramuscularly.

RITALIN® hydrochloride (methylphenidate hydrochloride CIBA)

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References: 1. Natenshon, A. L.: Dis. Nerv. System 17:392 (Dec.) 1956. 2. Landman, M. E., Preisig, R., and Perlman, M.: J. M. Soc. New Jersey 55:55 (Feb.) 1958. 3. Carter, C. H., and Maley, M. C.: Dis. Nerv. System 18:146 (April) 1957.

CIBA SUMMIT, N. J.

Letters

'The Midwest's Best'

SIRS: A recent article points out that the great men of medicine come from the East. To which I'd add, so does the trouble. But this latter distinction must be shared with the Far West. These two areas have the highest malpractice insurance rates—probably because they deserve them.

From what I read, it's apparently common practice for Eastern doctors to charge $100 for surgery at a teaching hospital when the doctor rendering the bill has never even seen the patient. In the Middle West, we call it "ghost surgery."

These same Eastern doctors tell the rest of the country that the family practitioner who knows the patient best must have absolutely nothing to do with him once he's in the hospital for surgery.

As for the Far West—well, if doctors there charge as much as all reports indicate they do, no wonder doctor-patient relations are so poor.

Thank Heaven for the Middle West! Here we get on with one another pretty well; none of us suffer from hunger; and most of us have the respect and loyalty of our patients—who live about as long as those in any other section of the country.

Raymond J. Doherty, M.D.
Merrillville, Ind.

Malpractice Mishap?

SIRS: In "How to Get Hit With a $75,000 Malpractice Verdict," you report that Dr. Edgar L. Pennell Jr. of Philadelphia has been held responsible for the negligent acts of hospital employes who were taking care of his patient. The defense was based on the contention that the doctor wasn't responsible for hospital employes' acts. Yet clearly it should have been based on the simple contention that there'd been no negligence by *anyone*.

The alleged negligence consisted of giving penicillin to a patient who'd warned he was allergic to it. Six days later, he developed a rash, followed next morning by a stroke, with paralysis of the right arm and blindness in the right eye.

As an allergist, I believe it's extremely unlikely that the stroke was caused by reaction to the penicillin. More important, it's clear that the patient suffered a serum-

Letters

sickness type of reaction. There's absolutely no way to predict that a patient will develop such a reaction. For the patient who does is *not* allergic before the injection. The allergic patient will react immediately, not several days later.

Murray Dworetzky, M.D.
New York, N.Y.

SIRS: ...The patient's stroke may well have been entirely unrelated to a presumed penicillin allergy. If the verdict is allowed to stand, similar lawsuits could arise in any doctor's practice where the patient has a stroke.

A. J. Lipsey, M.D.
Gary, Ind.

The Right to Pay

SIRS: In his article "We Need More—Not Less—Professional Courtesy," Dr. James Denny says he refuses to sell his soul by accepting an insurance payment for treating a colleague. I wonder if Dr. Denny ever considers what his attitude does to the soul of the other doctor.

This colleague pays the premiums because *he* feels better paying for medical services instead of sending a thank-you note or a basket of fruit.

After all, there's nothing sacred about medical treatment. If he wants, the recipient should have the right to pay for it.

All of us feel honored to serve another physician and his family. So, to be truly considerate of his feelings, let's accept graciously whatever he chooses to offer—a verbal or written thank-you, a gift, or a payment of money.

M.D., Washington

Social Security View

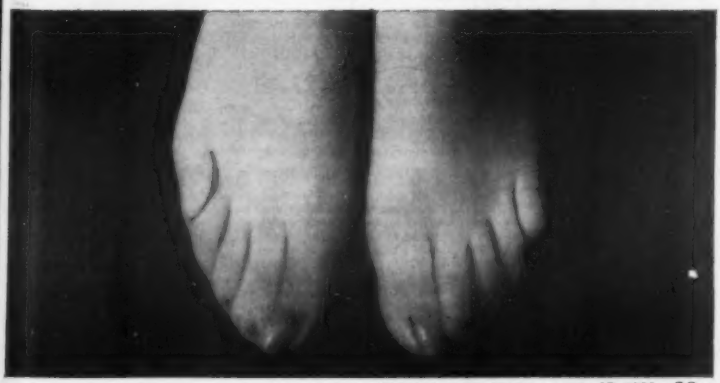
SIRS: I understand that at least 30 per cent of all physicians are now covered by Social Security through service in the Armed Forces or industrial employment. Hence it seems unjust to leave the others out merely on the basis of views expressed by A.M.A. leaders who refuse to poll practicing physicians on how they actually feel about the question.

It's interesting to note that the governing board of the American Dental Association had a similar attitude until it was overruled by the massive protest of practicing dentists.

James C. Walker, M.D.
Dayton, Ohio

How Americans Spend

SIRS: In a recent News Brief, you gave Government figures to show that Americans annually spend (in billions of dollars) $3.2 on alco-



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- has been reported to be effective even in patients who do not respond satisfactorily to other diuretics
- has prompt onset of action with diuretic effectiveness maintained even on prolonged daily administration
- low toxicity—extremely well tolerated
- often achieves the benefits of a low salt diet without the unpleasant restriction

indications: Hypertension, congestive heart failure of all degrees of severity, premenstrual syndrome (edema), edema and toxemia of pregnancy, renal edema—nephrosis, nephritis; cirrhosis with ascites, drug-induced edema, and as adjunctive therapy in the management of obesity complicated by edema.

dosage: In edema—one or two 50 mg. tablets of HYDRODIURIL once or twice a day.

In hypertension—one or two 25 mg. tablets or one 50 mg. tablet HYDRODIURIL once or twice a day.

supplied: 25 mg. and 50 mg. scored tablets HYDRODIURIL (Hydrochlorothiazide) in bottles of 100 and 1,000.

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Additional information on HYDRODIURIL is available to the physician on request.

bibliography: 1. Esch, A. F., Wilson, I. M. and Freis, E. D.: 3,4-Dihydrochlorothiazide: Clinical Evaluation of a New Saluretic Agent. Preliminary Report; M. Ann. District of Columbia **28**:9, (Jan.) 1959. 2. Ford, R. V.: The Clinical Pharmacology of Hydrochlorothiazide; Southern Med. J. **52**:40, (Jan.) 1959. 3. Fuchs, M., Bodi, T., Irie, S. and Moyer, J. H.: Preliminary Evaluation of Hydrochlorothiazide ('HYDRODIURIL'); M. Rec. & Ann. **51**:872, (Dec.) 1958. 4. Moyer, J. H., Fuchs, M., Irie, S. and Bodi, T.: Some Observations on the Pharmacology of Hydrochlorothiazide; Am. J. Cardiol. **3**:113, (Jan.) 1959.

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- loss of potassium is clinically insignificant in the great majority of patients on normal diets

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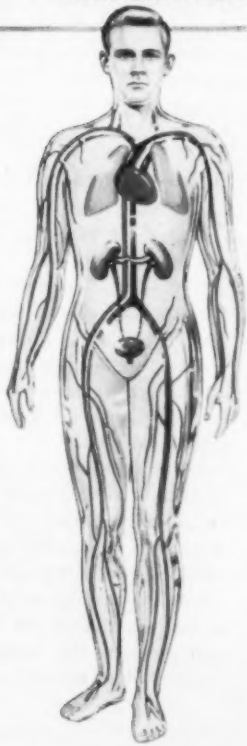
- effective by itself in some patients—markedly potentiates other antihypertensive agents
- provides background therapy to improve and simplify the management of all grades of hypertension
- has been reported by some investigators to have a greater antihypertensive effect in some patients than chlorothiazide at equivalent dosage
- does not lower blood pressure in normotensives
- reduces dosage requirements for other antihypertensive agents, often with concomitant reduction in their distressing side effects
- smooths out blood pressure fluctuations



Precautions: It is important that the dosage be adjusted as frequently as the needs of the individual patient demand. When HYDRODIURIL is used with a ganglion blocking agent, it is mandatory to reduce the dose of the latter by at least 50 per cent, immediately upon adding HYDRODIURIL to the regimen.

HYDRODIURIL has shown no adverse effects on renal function; for this reason it may be used with excellent results even in patients for whom the organomercurials are contraindicated because of renal damage.

The excretion of potassium is much lower than that of sodium or chloride and, as is the case with DIURIL®, the loss of potassium is clinically insignificant in the great majority of patients on normal diets. If indicated, potassium loss may easily be replaced by including potassium-rich foods in the diet (orange juice, bananas, etc.).

MSD MERCK SHARP & DOHME

Division of Merck & Co., INC. Philadelphia 1, Pa.

Letters

holic drinks, $2.1 on tobacco, and $1.3 on doctor bills.

I'm certain that the last figure, at least, is incorrect. It works out to only about $8,000 per practicing physician.

M.D., New Jersey

The figures shouldn't have been given as dollars, but as percentages of annual personal expenditures—which in 1957 totaled $284 billion. Doctor bills accounted for 1.3 per cent of this, or $3.69 billion.—ED.

Illusory Insurance?

SIRS: You recently reported on a new type of term insurance that's sold on a "buy now, pay later" basis. The insurance company lends the policyholder the accumulated cash value of the policy each year. He applies this, plus the dividends, against the premium payments, so that his premiums are greatly reduced.

But this "minimum deposit insurance" can be a snare and a delusion. Some insurance salesmen make this new coverage seem a bargain by painting a glowing picture of increasingly large dividends to be paid during the life of the policy. Even the MEDICAL ECONOMICS illustration of a "typical" minimum deposit policy showed dividends soaring from about 6 per cent of the premium in the second policy year to almost 40 per cent by the twentieth year. Yet how can any company predict dividends twenty years ahead on such a new type of policy?

It can't be done even on the old established types of policy. According to a recent report of Acacia Mutual Life, "a review of the twenty largest U.S. life insurance companies for which . . . dividend records are available for a typical policy . . . shows a startling fact. The . . . average yearly dividend these companies estimated in 1933 they would pay over the next twenty years was 38 per cent greater than [what] they actually did pay . . . This is conclusive proof that it is impossible for any company to even approximately forecast the amount of dividends that it will pay over a period of years."

In my opinion, minimum deposit life insurance has at best a very limited application. I see it only as a possible supplement to basic insurance coverage for people in at least the 50 per cent income tax bracket, where tax savings can further reduce the premiums.

William Harmelin

Business Estate Planning Consultants, Inc.
New York, N.Y.

END

For anything that

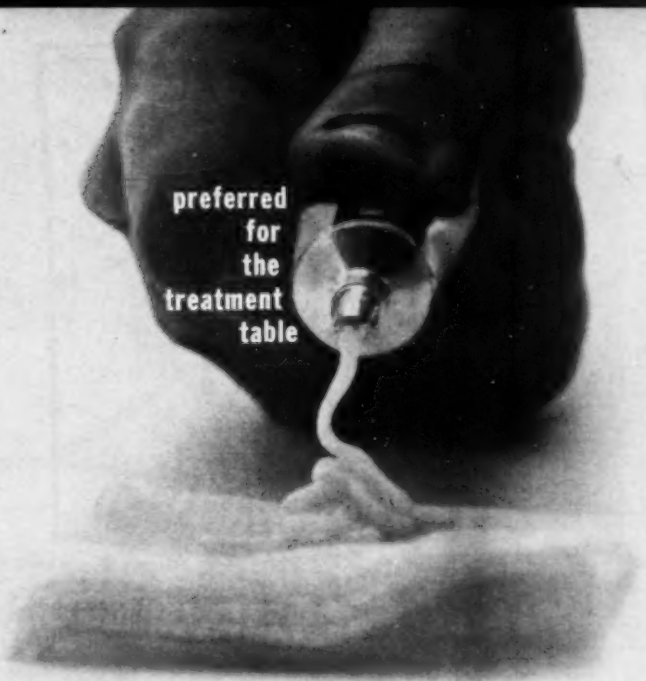
itches

use Calmitol *first*

. . . for every type of pruritus, CALMITOL® is the fast acting conservative, low-cost, nonsensitizing antipruritic. Supplied: tubes, 1½ oz., and 1-lb. jars of nonirritant, easy-spreading ointment. For severe itching, CALMITOL Liquid, 2-oz. bottles.

Thos. Leeming & Co. Inc. 155 East 44th Street, New York 17.


dosage problem with
muscle relaxants?
no problem with
PARAFLEX®
Chlorzoxazone*
just 6 tablets daily is an
average effective dose
Benefits of a 1- or 2-tablet dose persist for about 6 hours, relieving pain and stiffness and improving function in musculoskeletal disorders such as low back syndrome, sprains, strains, myalgia, fibrositis, and stiff neck. Side effects are rare, almost never require discontinuance of therapy.
Supplied: Tablets, scored, orange, bottles of 50. Each tablet contains PARAFLEX, 250 mg.
6
McNEIL
McNeil Laboratories, Inc • Philadelphia 32, Pa.
*U.S. Patent Pending



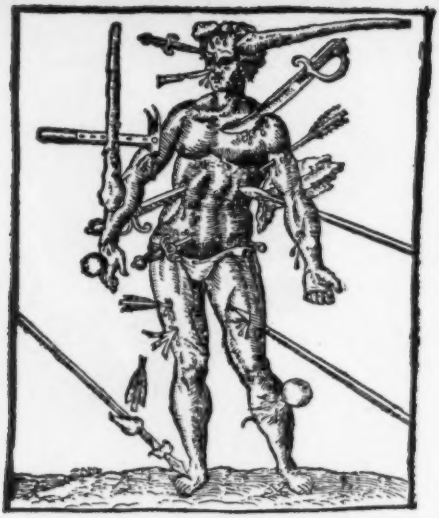
because Neo-Polycin Ointment

helps clear topical infections promptly

Neo-Polycin® provides neomycin, bacitracin and polymyxin, the three antibiotics preferred for topical use because this combination is effective against the *entire* range of bacteria causing most topical infections...has a low index of sensitivity...and averts the risk of sensitization to lifesaving antibiotics, since these agents are rarely used systemically. And Neo-Polycin provides these three antibiotics in the unique Fuzene® base, which releases higher antibiotic concentrations than is possible with grease-base ointments.

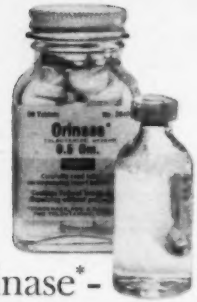
Each gram of Neo-Polycin contains 3 mg. of neomycin, 400 units of bacitracin and 5000 units of polymyxin B sulfate in the unique Fuzene base. Supplied in 15 Gm. tubes

PITMAN-MOORE COMPANY, DIVISION OF ALLIED LABORATORIES, INC., INDIANAPOLIS 6, INDIANA



Wound Man from 16th-century Surgery of Ambroise Paré

When you give a salicylate to relieve pain, you will get better results with ASCRIPTIN – *aspirin buffered with our antacid* MAALOX®. ASCRIPTIN *is indicated for pain relief in every condition where salicylates are useful and especially in arthritis, rheumatism and other chronic illnesses that require prolonged analgesic medication. The dose is that of aspirin, but* ASCRIPTIN *relieves pain faster, without gastric disturbance and produces significantly higher blood salicylate levels* (N.Y. State J. Med. 58:697, 1958). *Moreover, since* ASCRIPTIN *is a professional preparation, not advertised to your patient, a prescription for it has maximal psychological effect. The* ASCRIPTIN *tablet disintegrates quickly to provide acetylsalicylic acid 0.30 Gm. and* MAALOX (*magnesium aluminum hydroxide gel*) *0.15 Gm. Make your own comparisons; we'll be glad to send you a clinical supply with our compliments.* ASCRIPTIN *is available at prescription pharmacies in bottles of 100 and 500. For severe pain, capsules* ASCRIPTIN *with* CODEINE (*codeine phosphate, 15 mg.*) *are also available.* WILLIAM H. RORER, INC., *Philadelphia 44, Pa.*



Combined Orinase*-insulin therapy enables you to "stabilize" a surprising percentage of "brittle" diabetics

The primary indication for Orinase remains in the stable, maturity-onset diabetic in whom Orinase usually can fully replace insulin therapy. But now a further indication has developed from the cumulative data of the past several years: many labile diabetics, who cannot be managed on Orinase alone, can benefit from the *addition* of Orinase to their insulin regimen.

A major benefit—stabilization

In the labile diabetic who successfully responds to joint insulin-Orinase management, the "peaks and valleys" of erratic blood sugar levels are rarely observed. The addition of Orinase greatly reduces sudden and unexpected changes . . . tends to "stabilize" even the "brittle" diabetic.

A major benefit—lessened insulin needs

The Orinase-stabilized labile diabetic generally requires less insulin than before the inclusion of Orinase in his regimen. This lessening of insulin dosage is particularly advantageous in the patient who is insulin-dependent, but who reacts unfavorably —whether by lipodystrophy or otherwise—to insulin.

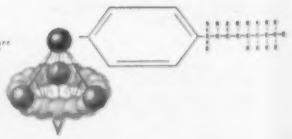
The derived benefits—less hypoglycemia, less anxiety, greater well-being

With stabilization, the hazards of shock or coma are diminished. Like the diabetic who is responsive to Orinase alone, the labile diabetic on combined therapy need no longer walk a slender tightrope between hypo- and hyperglycemia. The patient's fears are greatly lessened . . . often to be replaced by the healthier outlook characteristic of *euglycemic* Orinase management. *TRADEMARK, REG. U. S. PAT. OFF.—TOLBUTAMIDE, UPJOHN

Upjohn

The Upjohn Company
Kalamazoo, Michigan

AN EXCLUSIVE METHYL "GOVERNOR" PREVENTS HYPOGLYCEMIA . . . MAKES ORINASE A TRUE EUGLYCEMIC AGENT



News • News • Ne

Investors Advised to Hunt 'Tomorrow's Blue Chips'

"We have the same problem as individual investors, though on a larger scale," declares the president of one closed-end investment company. The problem: "We can't afford speculation, don't believe the prices of many blue chips are realistic at today's market, and yet need to maintain both growth and income."

Your problem too? Then, says Madison Fund's Edward A. Merkle, your best bet is search out "sleeper stocks." To Merkle, a "sleeper" is a company "with the potential to become a blue chip, but not generally well known to the investing public."

Don't expect to find these "blue chips of the future" through hunches or tips, cautions Merkle. "It takes real investigation to dig [them] up." Here are the things he looks for:

1. "Excellent quality as an investment, independent of potential." The tip-off: a consistent earnings record and a solid return on invested capital.

2. "Prospects—in new products, new industries, or other specific areas—of sharply improved earnings or increased stature, though not necessarily in the immediate future."

3. Adequate facilities, working capital, and management skills for realizing the company's potential.

Merkle offers as examples American Machine and Metals, Central Soya Company, Philips Incandescent Lamp Works Holding Company, Public Service Company of New Mexico, and Southdown Sugars. He says all were sleepers when the Madison Fund added them to its holdings. None individually exceeds 1 per cent of the fund's total assets.

In sum, Merkle tells individual investors: "Several sleeper stocks can become an important part of a diversification program without throwing [your] entire portfolio out of balance."

Do These Compensation Fees Top Your Private Fees?

California fees, already the envy of many doctors outside the Golden State, may become even more so if the California Medical Association gets the workmen's compensation fee schedule it's asked for. Then

News · News

California doctors would get paid more for workmen's compensation cases than many medical men elsewhere are paid by private patients.

The medical association has recommended these increases:

¶ First office visit: from $5 to $7.

¶ First house call: from $7 to $8.

¶ First hospital call: from $6 to $7.

In addition, the association has asked that doctors be paid $16 an hour (instead of the current $15) in workmen's compensation cases when they're detained at a patient's bedside.

Just for comparison: The latest MEDICAL ECONOMICS survey disclosed that G.P.s' charges to private patients average out nationally between $3 and $4 for office visits and between $5 and $6 for house calls.

Home-Buying to Be Eased If Trade-In Bill Passes

Doctors may soon be able to trade in their house on a new one in much the same way as they trade in a car. That's the prediction from Washington observers. They think Congress is certain to give a boost to trade-in deals on housing this year.

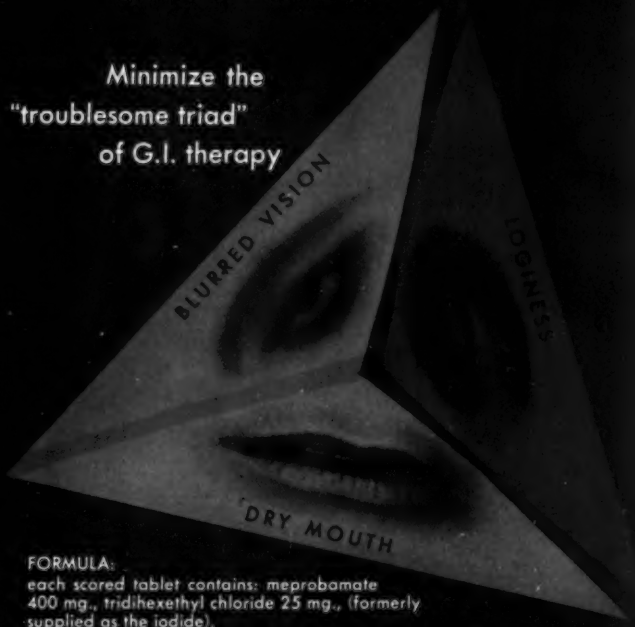
Already some real estate men have been experimenting with trade-ins. They buy the old house, then sell it when they can. Most

When other G.I. therapy failed because of troublesome side effects, Bandes *et al.* controlled symptoms in 90% of cases with complete freedom from side effects in 85% with

Milpath®

®Miltown + *anticholinergic*

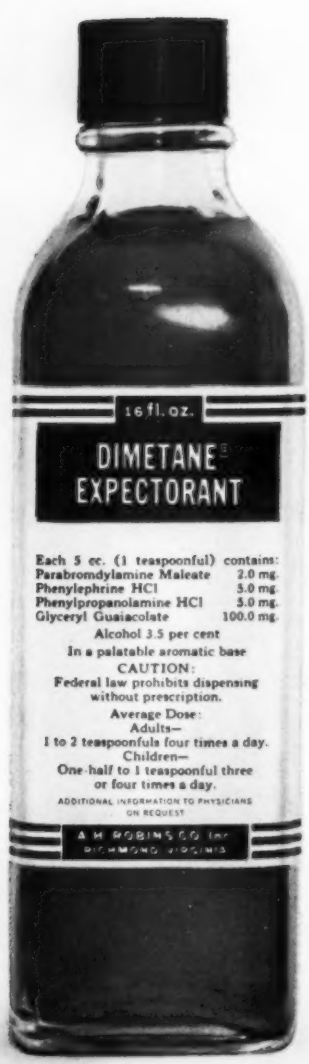
Minimize the "troublesome triad" of G.I. therapy



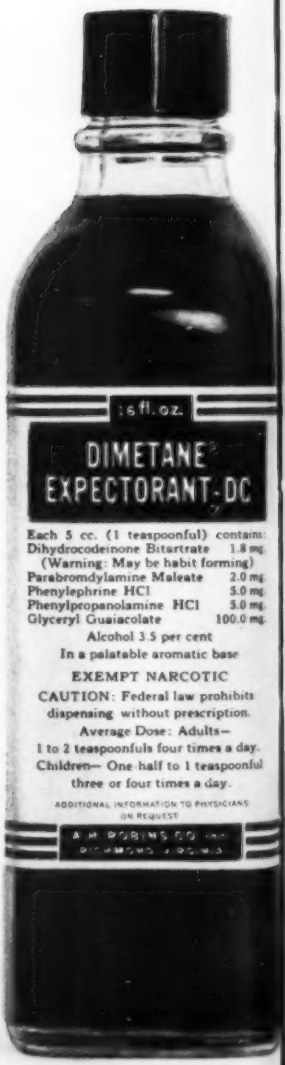
FORMULA:
each scored tablet contains: meprobamate 400 mg., tridihexethyl chloride 25 mg., (formerly supplied as the iodide).

1. Bandes, J.: Combined Drug Therapy in Gastrointestinal Disturbances; Increased benefit through diminished side reactions, Am. J. Gastroenterol. 30:600, Dec. 1958.

WALLACE LABORATORIES *New Brunswick, N. J.*



read the labels on these delicious new cough products to see why they work better.



brokers would do this, they say, if they had the ready cash.

That's where Congress is expected to help. The idea is to let the Federal Housing Administration insure trade-in loans to brokers. And the plan is a part of all three housing bills now being considered in Congress.

Doctors Get Fast Action on Complaint About Ad

What can doctors do about advertisements that falsely imply a product has medical men's approval? Some New York doctors recently tried complaining to their county medical society president about one such case. They found it took just two weeks to get the advertisement stopped.

Bumbalo

What happened is shown in the two letters excerpted here. The first is from Dr. Thomas S. Bumbalo, Erie County (N.Y.) Medical Society president, to the A.M.A.'s executive vice president, Dr. F. J. L. Blasingame:

"The Erie County Medical Society wishes to bring to the attention of the A.M.A. . . . the type of advertising currently being employed by the Serta Mattress Company . . . over station WBEN-TV [in Buffalo]," Dr. Bumbalo wrote.

"TV viewers first are told that the Serta mattress is warmly endorsed by . . . the Chiropractic Association of New York, and carries their seal of approval . . . This is followed by a close-up shot of the Good Housekeeping Magazine Seal of Approval. Climaxing all this comes the announcement that Serta mattresses are 'advertised in the Journal of the A.M.A.' and bear the Seal of Approval of the A.M.A., which is flashed on the screen. . .

"It would be a matter of real gratification," Dr. Bumbalo concluded, "if you would assure us that you intend to crack down on the Serta Company."

Two weeks later, he got this answer from C. Joseph Stetler, director of the A.M.A.'s Law Department:

"The A.M.A. discontinued its [product] acceptance program in 1955, and at that time we advised all companies, including Serta . . . to cease . . . making reference to A.M.A. acceptance. . .

"We [have] contacted Serta associates here in Chicago concerning the advertisement on WBEN-TV. [Serta's] vice president in charge of sales promotion . . . has

HIGHLIGHTS FROM THE A.M.A. COUNCIL ON DRUGS

REPORT ON TRIAMCINOLONE

J.A.M.A. 169:257 (January 17) 1959.

"It [triamcinolone] has an anti-inflammatory potency greater than an equal amount of prednisolone; i.e., comparable suppressive effects may usually be achieved with lower doses of triamcinolone than with prednisolone."

"Triamcinolone lacks the sodium-retaining and edema-producing effects of most other glucocorticoids. During the first several days of administration, it may cause a loss of sodium from the body; an initial mild diuretic action is frequently observed, whether the patient is frankly edematous or not. This is in contrast to the definite sodium-retaining and fluid-retaining properties of cortisone and hydrocortisone and to a much lesser extent with prednisone and prednisolone."

"Except in exceedingly large doses, triamcinolone apparently has no consistent effect on potassium excretion. Hence, neither sodium restriction nor potassium supplementation is ordinarily required during therapy with this agent."

"As with other glucocorticoids, the long-term administration of triamcinolone results in definite catabolic effects, as indicated by impairment of carbohydrate utilization and negative protein and calcium balance. This catabolic effect, coupled with a lack of appetite stimulation which is apparently peculiar to triamcinolone, may produce weight loss that might be undesirable in some patients treated for long periods of time."

"... the voracious appetite, with weight gain and euphoria, characteristic of other steroids, is not seen with administration of triamcinolone."

"Triamcinolone has been used for the management of a wide variety of clinical conditions usually considered amenable to systemic steroid therapy. These have included rheumatoid arthritis and other collagen diseases, allergic and dermatological disorders, certain leukemias and malignant lymphomas, the nephrotic syndrome, pulmonary emphysema and fibrosis, acute bursitis, rheumatic fever, and certain blood dyscrasias. Although clinical experience with the drug in some of the foregoing conditions is not extensive, the many similarities in action between triamcinolone and other potent glucocorticoids would indicate a usefulness for triamcinolone akin to that of other agents of this class."

"There is some evidence that triamcinolone is more effective at a smaller dosage than are other steroids in controlling both the skin and joint lesions in psoriasis, whether or not complicated by arthropathy."

"Triamcinolone appears to compare favorably with other steroids for use in those situations in which edema and sodium retention have been complicating problems."

"It [triamcinolone] may also be the steroid of choice for patients in whom psychic stimulation, euphoria, voracious appetite, and weight gain should be avoided."

"... the drug [triamcinolone] does produce the other side effects and untoward reactions common to the glucocorticoids. At therapeutically equivalent doses, the frequency and severity of clinical manifestations of hyperadrenalism – rounding of the face, fat deposition, and hirsutism – are essentially the same. Likewise, there is little indication that the relative incidence of osteoporosis is materially decreased after the long-term use of the drug."

"Triamcinolone apparently does not cause the euphoria sometimes seen with other steroids, and the occurrence of mental depressions is uncommon."

"Current evidence suggests that the drug [triamcinolone] may not produce as high an incidence of peptic ulcer as do other steroids."

"Cutaneous erythema seems to be a side effect peculiar to triamcinolone."

"The usual contraindications and precautions of glucocorticoid therapy should be followed in the use of triamcinolone, keeping in mind that prolonged therapy with this drug will suppress the function of the patient's own adrenals by interfering with the pituitary-adrenal axis."

Aristocort®

Triamcinolone LEDERLE

Supplied: 1 mg. scored tablets (yellow)
2 mg. scored tablets (pink)
4 mg. scored tablets (white)

Lederle LEDERLE LABORATORIES
A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

advised us that the owner of the franchise in Buffalo will discontinue the commercial immediately."

How the Mutual Funds Did During the Boom

The reports are in on how the various mutual funds performed last year. The verdict: "One of the best years in history." That's the word from Barron's Financial Weekly, which keeps tabs on 165 leading open-end investment funds. During 1958 those funds averaged an increase in per-share value of nearly one-third, or 32.5 per cent. (The increase consists of market-value appreciation of their holdings plus realized capital gains.)

This gain is a trifle less than the 34 per cent advance made by the Dow-Jones average of thirty industrial stocks. But Wall Streeters point out that the funds chalked up their 32.5 per cent over-all gain even though some of them are committed to holding bonds and preferred stock. Such funds "can't be expected to keep pace with a market index made up only of common stocks," Barron's notes.

But seventy-two funds did better than the Dow-Jones industrial index, posting gains of 35 per cent or more. The adjoining table shows

Twelve Top Performers Among Mutual Funds

	1958 Gain
Keystone Custodian Funds' Series S-4 (Lower-Priced Common Stocks)	*77.8%*
Group Securities' Steel Shares	*63.7*
Group Securities' Electronics & Electrical Equipment	*63.6*
Group Securities' Railroad Stock	*55.6*
Group Securities' Tobacco	*55.4*
Diversified Growth Stock	*54.5*
Crown Western Investments' Dallas Fund	*53.5*
Dreyfus	*49.8*
Television-Electronics	*48.9*
Keystone Custodian Funds' Series K-2 (Growth Securities)	*48.5*
Group Securities' Railroad Equipment	*46.6*
Massachusetts Investors Growth Stock	*46.5*

Source: Barron's Financial Weekly

d age must be
sisted and its
ficiencies
upplied"
—CICERO

to help your patients resist old age prescribe

ELDEC®

vitamin-mineral-hormone supplement

KAPSEALS®

during the middle years

each KAPSEAL *contains:*

vitamins	
Vitamin A	1,667 Units (0.5 mg.)
Vitamin B_1 mononitrate	0.67 mg.
Ascorbic acid	33.3 mg.
Nicotinamide	16.7 mg.
Vitamin B_2	0.67 mg.
Vitamin B_6	0.5 mg.
Vitamin B_{12} with intrinsic factor concentrate	0.033 USP Unit (oral)
Folic acid	0.1 mg.
Choline bitartrate	6.67 mg.
Pantothenic acid (as the sodium salt)	5 mg.
minerals	
Ferrous sulfate (exsiccated)	16.7 mg.
Iodine (as potassium iodide)	0.05 mg.
Calcium carbonate	66.7 mg.
digestive enzymes	
Taka-Diastase®	20 mg.
Pancreatin	133.3 mg.
protein improvement factors	
l-Lysine monohydrochloride	66.7 mg.
dl-Methionine	16.7 mg.
gonadal hormones	
Methyl testosterone	1.67 mg.
Thevelin	0.167 mg.

dosage: One Kapseal three times daily before meals. Female patients should follow each 21-day course with a 7-day rest interval.

packaging: ELDEC Kapseals are available in bottles of 100.

MEDICAMENTA VERA

PARKE, DAVIS & COMPANY, Detroit 32, Michigan

ELDEC BEGINS AT 40

the twelve top performers, as reported by Barron's.

Only two of the 165 mutual funds surveyed by Barron's declined in value last year. Both were funds that specialize in bonds. Group Securities' Institutional Bond Fund declined 1.5 per cent, and Keystone Custodian Funds' B-1 (High-Grade Bonds) declined 1.1 per cent.

Last year's record contrasts sharply with what happened to mutual funds in 1957. All but five funds declined in per-share value, and the average decrease for the group was 13.9 per cent. So you can expect fund men to make the most of last year's impressive comeback as a selling point in 1959.

Doctor-Patient Confidences No Longer Confidential?

Is the day coming when a doctor can be compelled in court to reveal all he knows about a patient? A noted law professor sees signs that this may be so. Says Clinton DeWitt of Western Reserve University: "Perhaps the physician-patient privilege is on the way out."

State legislatures have already "all but canceled out" protection from disclosure outside the courtroom, according to Professor DeWitt. In his recent book, "Privileged Communications Between Physician and Patient" (Charles C Thomas, Springfield, Ill., publisher; 528 pages), he notes that doctors now must report medical confidences in connection with such things as death certificates, drunk driver tests, venereal disease records, and insanity examinations. The net effect, as DeWitt sees it: "Today few medical confidences... can really be kept secret" outside court.

Inside the courtroom, the same trend can be seen. "Justice cries out for the facts," says Professor DeWitt; and sometimes the physician-patient privilege gets in the way.

What about doctors' fear that patients won't confide in them without the protection of privilege? Professor DeWitt feels the Hippocratic oath is enough to encourage the patients' confidences. And he makes these points to argue that privilege does little good:

1. Few patients have ever heard of privilege; yet they entrust "their most intimate and delicate secrets to their medical advisers" just the same. And, he adds, that includes patients in the seventeen states that do not recognize privilege.

2. The patient really gets very little assurance of secrecy from privilege. Why? Because it applies only in court. "As far as the statute goes, the physician may talk about

reduces anginal attacks
and fear of attacks

protects against pain by sustained coronary vasodilatation and control of complicating and triggering emotions

reduces fear of attacks
reduces severity of attacks
reduces frequency of attacks
reduces dependence on nitroglycerin
increases workload tolerance

Supplied: Tablets, vials of 50. Each tablet contains 200 mg. of meprobamate and 10 mg. of pentaerythritol tetranitrate.

EQUANITRATE*

Meprobamate and Pentaerythritol Tetranitrate, Wyeth

Wyeth
Philadelphia 1, Pa.

*Trademark

the ailments of the patient from New York to San Francisco and to every Tom, Dick, and Harry on the street," he says.

3. Privilege hasn't actually been invoked to protect patients' privacy or prevent humiliation. Instead, the "primary motive" seems to have been "winning a lawsuit by excluding relevant and material evidence," reports DeWitt.

All this has brought on increasing criticism of privilege by members of the bench and bar in recent years. It's been called a "farce," a "parody on justice," "misguided sentimentality," and "monumental hoax."

Even so, DeWitt doesn't expect legislatures to abolish privilege "within a reasonable length of time." Instead he thinks they might well follow the lead of North Carolina. There the privilege statute has been amended to allow a judge to compel a physician to testify if in the court's opinion it's "necessary to a proper administration of justice."

Stockbrokers' Fees Are a Little Lower Now

Buying securities listed on the New York stock exchanges is now a trifle lighter on the investor's pocketbook. Brokers' commissions went up just a year ago; now those on orders of less than $2,400 have taken a small dip, averaging 5.3 per cent.

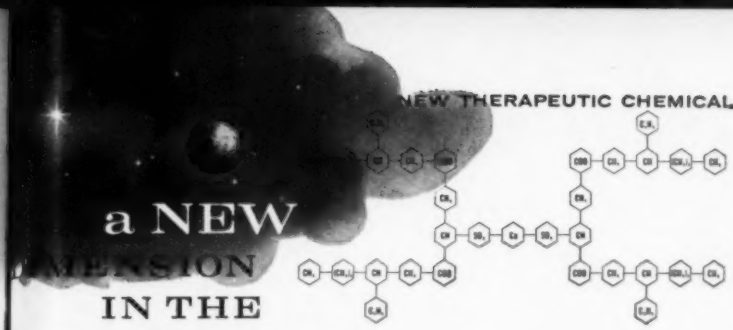
One example of the savings: A doctor who buys or sells 100 shares worth a total of $1,000 will now pay a $17 commission. Last month he would have paid $18.

Why have brokers given the small investor this break? They did it at the "suggestion" of the Securities and Exchange Commission. Investment men think the trimmed commissions will soon become standard in exchanges across the country too.

Doctors Seek to Solve a Colleague's Slaying

Murder is hardly a routine item on a medical society agenda. But the Richmond (Va.) Academy of Medicine has taken action in the recent slaying of its past president, a nationally known urologist, Dr. Austin I. Dodson. Members are offering a reward for information leading to the arrest of his killers.

Dr. Dodson was bludgeoned to death on his way to a concert one evening last February. He had dropped his wife off at the auditorium, parked his car several blocks away, and was walking back through a mid-city park when two men attacked him. Several thousand concert-goers and four policemen were virtually within ear-



a NEW DIMENSION IN THE TREATMENT OF CONSTIPATION

DOXIDAN

The Surfactant Laxative

"Ideal" laxative therapy has now been made possible by the application of a new principle based on the double surfactancy of the new therapeutic chemical, calcium bis-(dioctyl sulfosuccinate).

Doxidan provides positive, reliable laxative action with:

- Greatly reduced laxative dosage and optimal surfactancy.
- The least possible disturbance of normal body physiology.
- Freedom from the discomfort of bowel distention.
- Freedom from "oily leakage" and interference with vitamin absorption.
- Freedom from pain and "cramping."
- Greatly reduced risk of laxative habituation.

No longer is a "cathartic flush" needed to expel a hardened resistant fecal mass. Instead, once calcium bis-(dioctyl sulfosuccinate) has rendered the mass malleable and mobile, a gentle peristaltic stimulant is all that is needed to correct bowel dysfunction.

Doxidan is a true synergistic combination of calcium bis-(dioctyl sulfosuccinate), the new surfactant fecal softener, and Danthron, a mild peristaltic stimulant which acts solely in the lower bowel.

This new dimension in treatment (Doxidan therapy) results in soft, "normal" stools gently stimulated to evacuation.

formula: **Each maroon soft gelatin capsule contains 50 mg. Danthron (1,8-dihydroxyanthraquinone) and 60 mg. calcium bis-(dioctyl sulfosuccinate).**

dosage: **For adults and children over 12, one or two capsules. For children, age 6 to 12, one capsule. Give at bedtime for 2 or 3 days or until bowel movements are normal.**

supplied: **Bottles of 30 and 100 soft gelatin capsules.**

LLOYD BROTHERS, INC. CINCINNATI 3, OHIO

shot when Dr. Dodson was attacked, and three witnesses say they got a glimpse of the assailants. Yet the murder is still unsolved.

So Dr. Dodson's colleagues have posted a $1,500 reward with the Richmond police for information leading to the killers' arrest.

Pill Peddlers Aren't Stupid

Door-to-door medicine peddlers in Germany have come up with a new product that could spell trouble if it catches on in the U.S. It's "anti-stupidity" pills. Police in the south German town of Burg Preppach have given up trying to jail any of the peddlers, because no one who's bought the pills will admit he's been gypped.

His Good-By to Patients Collects Back Bills

A Midwestern physician recently decided to move to a new location after more than three decades of practice in one community. Here's how he said good-by to old friends and at the same time collected the back bills some of them owed him:

Several weeks before he left St. Charles, Minn., Dr. Raymond L. Page ran a paid notice in the local paper. This open letter to his patients told them he'd be leaving soon and thanked them for their loyalty. The notice prompted many patients to settle at once—but not all of them. So a week before he left, Dr. Page sent this notice to every patient with an unpaid account still on his books:

"As you may have seen in the press or heard by now, I am leaving St. Charles . . . If you cannot settle this account at once, please see me or write me with very definite arrangements as to how and when you can. . .

"After I leave . . . as I will not be able to look after accounts closely here myself, I am having a commercial agency do the collecting for me. Any plans for payment which I have approved will be followed as agreed to. . ."

That notice brought in some $4,000 in immediate payments, Dr. Page reports. "It's surprising how many paid cash—even borrowed from the bank to do it. But I didn't press those who couldn't pay at once. I just asked them to make some definite arrangement: whatever they wanted to pay, on any schedule they thought they could meet."

What's more, nearly all the patients who made such arrangements stuck by them after Dr. Page left town, he reports. "And I played along with anyone just as long as I continued to hear from him."

What of the few who didn't take

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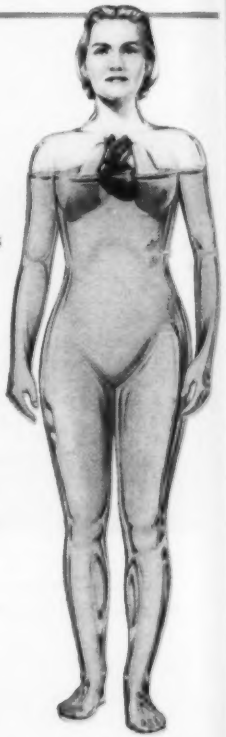
- each 25 mg. HYDRODIURIL orally is equivalent to 1.6 cc. meralluride I.M.
- has been reported to be effective even in patients who do not respond satisfactorily to other diuretics
- has prompt onset of action with diuretic effectiveness maintained even on prolonged daily administration
- low toxicity—extremely well tolerated
- often achieves the benefits of a low salt diet without the unpleasant restriction



Indications: Hypertension, congestive heart failure of all degrees of severity, premenstrual syndrome (edema), edema and toxemia of pregnancy, renal edema—nephrosis, nephritis; cirrhosis with ascites, drug-induced edema, and as adjunctive therapy in the management of obesity complicated by edema.

dosage: In edema—one or two 50 mg. tablets of HYDRODIURIL once or twice a day.

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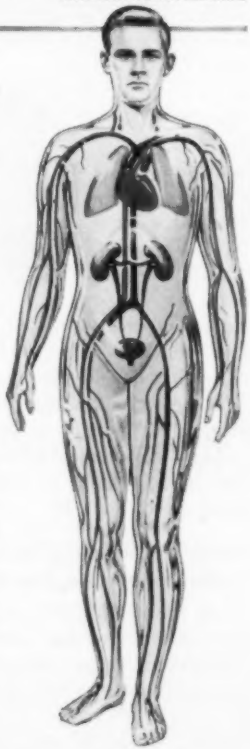

precautions: It is important that the dosage be adjusted as frequently as the needs of the individual patient demand. When HYDRODIURIL is used with a ganglion blocking agent, it is mandatory to reduce the dose of the latter by at least 50 per cent, immediately upon adding HYDRODIURIL to the regimen.

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the doctor up on his offer to arrange terms? "The collector's got their accounts now," he says. "They had plenty of chance to do it the friendly way."

What's the Hurry? Surgeon Asks Ambulance Drivers

Better than 98 per cent of the patients rushed to the hospital by ambulance would do as well if they'd come by oxcart. So concludes Surgeon Sydney N. Lyttle after surveying 2,500 ambulance deliveries to a Flint, Mich., hospital. He found that clanging gongs, screaming sirens, tire-screeching turns, and dashes through red lights do more harm than the minutes they save are worth.

Lyttle

His conclusion: There's no need for an ambulance to exceed the legal speed limit.

Hospital Didn't Operate, So Patient Balks at Paying

"I do not feel this is a just bill under the circumstances and do not feel obliged to pay," the patient reported to the grievance committee. The circumstances that bothered him: He'd been told he did *not* have appendicitis at a hospital where police had rushed him as an emergency case.

Earlier, on his way to work, he'd been stricken ill. At the hospital he was given tests, examined several times by an interne, then sent home. There his family doctor examined him, diagnosed acute appendicitis, and ordered immediate surgery at another hospital.

The first hospital sent a bill for emergency diagnostic services. Complained the patient: "They did nothing at all for me to show my condition was critical."

How did the mediation committee of the Cleveland academy of medicine decide the issue? The patient should pay, it ruled: "The bill was a just one and the patient was handled in the proper manner."

They're Easing the Way For Cadaver Donations

Doctors who've worked with agencies that collect corneas, arteries, skin, bones, and other body parts from recently deceased donors say their toughest nonclinical problem is to get consent from the next of kin. The same problem contributes to the medical schools' cadaver shortage. However, two states now have laws to simplify consent requirements, and it looks as if a third state will join them. *More*▶

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Laws adopted by Alaska and California in recent years do away with the necessity for the next of kin's consent. It's enough if an individual has specified that he wants to donate parts of his body for research or transplanting to another person. And a bill with the same provisions was passed last month by the New York Legislature and sent to the Governor.

Doctors Flock to Sign Up For Nonpleasure Cruise

Physicians and other medical personnel have been applying at a rate of 200 a day for a cruise to Southeast Asia. No vacation is involved. They're volunteering to staff the 800-bed hospital ship Consolation on a year-long goodwill voyage. The purpose: a nongovernmental mission to carry techniques of American medicine to medically underprivileged peoples.

The project—called Operation HOPE, for "health opportunity for people everywhere"—is sponsored by the People to People Health Foundation. President Eisenhower has endorsed the cruise, as has the A.M.A. Still to be arranged are the practical details of getting the Consolation under way this September. Two problems:

1. Selecting the doctors to serve aboard the ship. They'll lecture to foreign medical men and treat patients at the ship's ports of call.

2. Raising about $3,500,000 to pay for the project. (The ship itself is being lent by the Navy from its mothball fleet and will be operated at cost by the American President Lines. Contributions of supplies and some cash have been pledged by drug manufacturers.)

Where will the Consolation go? The foundation wants to send its floating medical school and treatment center wherever local Asian medical men invite her. It's anticipated that she can be especially valuable in epidemics.

"This is going to have a tremendous impact," predicts Operation HOPE's head man, Internist William Walsh of Washington, D.C. "It's a cheap way of waging peace."

Dr. Walsh thinks doctors will see the voyage as a way to extend the kind of medical pioneering being done by Albert Schweitzer and Thomas Dooley. Only about fifteen of the Consolation's medical staff will serve for the full year's cruise. The rest will be flown to the ship for three-month tours of duty. They'll be selected by a committee headed by Dr. John Z. Bowers, dean of the University of Wisconsin Medical School.

Suggests Dean Bowers: Volunteers will have a "unique, history-making" opportunity to exchange

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Clinical studies reveal that emotionally disturbed patients comprise the largest proportion of obese patients.[1] Bontril curbs the compulsive desire to eat by promoting emotional stabilization. Thus, better patient cooperation is assured.

1. Young, C. M., et al. (Study made in School of Nutrition, Cornell University), Am. Pract. Dig. Treat., 6:685, 1955.

Each tablet contains:

Dextroamphetamine Sulfate	5 mg.
Methylcellulose	350 mg.
Butabarbital Sodium	10 mg.

Dosage is flexible:

½, 1 or 2 tablets once, twice or three times daily. The usual dosage is one tablet upon arising and at 11 A.M. and at 4 P.M.

BONTRIL

Shrinks the appetite at the hunger peaks

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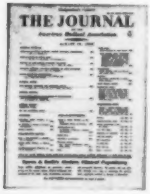
Question: Why do so many physicians prefer Cafergot and Cafergot P-B for migraine and other recurrent throbbing headaches?

Answers: By leading clinicians, quoted from their published investigations.



"The highest percentage (83%) of patients with symptomatic relief is obtained by early and adequate administration of ergotamine and caffeine (Cafergot), alone or combined with antispasmodics and/or sedatives (Cafergot P-B)."
(Friedman, A. P.: J.A.M.A. 163:1111, March 30, 1957.)

"For those patients in whom nausea and vomiting occur so early in the attack that oral medication cannot be used, rectal administration is sometimes a simple and effective solution. Cafergot suppositories...and Cafergot P-B suppositories ...are useful additions to the armamentarium."
(MacNeal, P. S., et al.: Management of the Patient with Headache, 1957.)

"The tablets [Cafergot P-B] were especially useful when the headaches were accompanied by nervous tension and gastrointestinal upset.... Cafergot P-B Tablets constitute an important addition to the treatment of vascular headache."
(Blumenthal, L. S., and Fuchs, M.: Med. Annals District of Columbia 26:175, April 1957.)

first choice
for migraine
and other recurrent,
throbbing headaches

CAFERGOT

CAFERGOT TABLETS
ergotamine tartrate 1 mg., caffeine 100 mg.
Dosage: **2 at first signs of attack; if needed, 1 additional tab. every ½ hour until relieved (max. 6 per attack).**

CAFERGOT SUPPOSITORIES
ergotamine tartrate 2 mg., caffeine 100 mg.
Dosage: **1 as early as possible in attack; second in one hour, if needed (max. 2 per attack).**

When the headache is associated with nervous tension and G.I. disturbance

CAFERGOT P-B TABLETS
ergotamine tartrate 1 mg., caffeine 100 mg., Bellafoline 0.125 mg., pentobarbital sodium 30 mg.
Dosage: **same as Cafergot Tablets.**

CAFERGOT P-B SUPPOSITORIES
ergotamine tartrate 2 mg., caffeine 100 mg., Bellafoline 0.25 mg., pentobarbital sodium 60 mg.
Dosage: **same as Cafergot Suppositories.**

SANDOZ

News · News

formation on disease and medical problems with Asian practitioners.

Medical men interested in shipping aboard may advise the People to People Health Foundation, P.O. Box 9808, Washington 15, D. C. Applicants are asked to give their educational background, including censure and certification information, a description of their present practice, and the reasons they'd like to sail with the project.

Stay-at-homes may have another chance, Dr. Walsh suggests. "There are four more hospital ships in mothballs," he notes.

Who's a Receptionist? Not Us, Say Aides

Which would your aide rather be called: a medical assistant, a medical secretary, or just Girl Friday? Chances are it doesn't make much difference to her, a recent A.M.A. survey indicates.

A group of aides visiting A.M.A. headquarters were given a list of titles and asked to select one or more that they felt fitted the work they do. Most of the girls picked several. Of 290 who responded, 54.5 per cent picked "medical assistant," 53.3 per cent picked "medical secretary," and 50.3 per cent picked Girl Friday. The only title less than half the girls chose was "receptionist." END

In the Treatment of Rheumatic Disorders Greater stability of maintenance dosage minimizes risks of hormonal imbalance

In Sterazolidin, the anti-inflammatory actions of prednisone and Butazolidin* are combined to permit lower effective dosage of each. Clinical experience has indicated that patients can be well maintained on this combination over prolonged periods with relatively low, stable dosage levels of each component, thus minimizing the problems arising from excessively high doses of corticosteroids. Other side effects have also been gratifyingly few. Antacid and spasmolytic components are contained in Sterazolidin capsules for the benefit of patients with gastric sensitivity.

Sterazolidin®: Each capsule contains prednisone 1.25 mg.; phenylbutazone 50 mg.; dried aluminum hydroxide gel 100 mg.; magnesium trisilicate 150 mg.; homatropine methylbromide 1.25 mg.

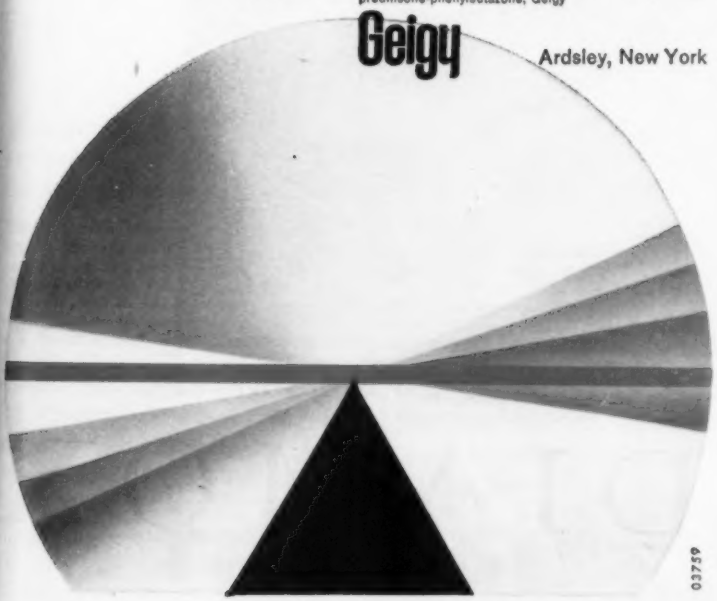
Detailed information available on request

*Geigy's trademark for phenylbutazone—Reg. U. S. Pat. Off.

new **Sterazolidin®** Capsules

prednisone-phenylbutazone, Geigy

Geigy Ardsley, New York



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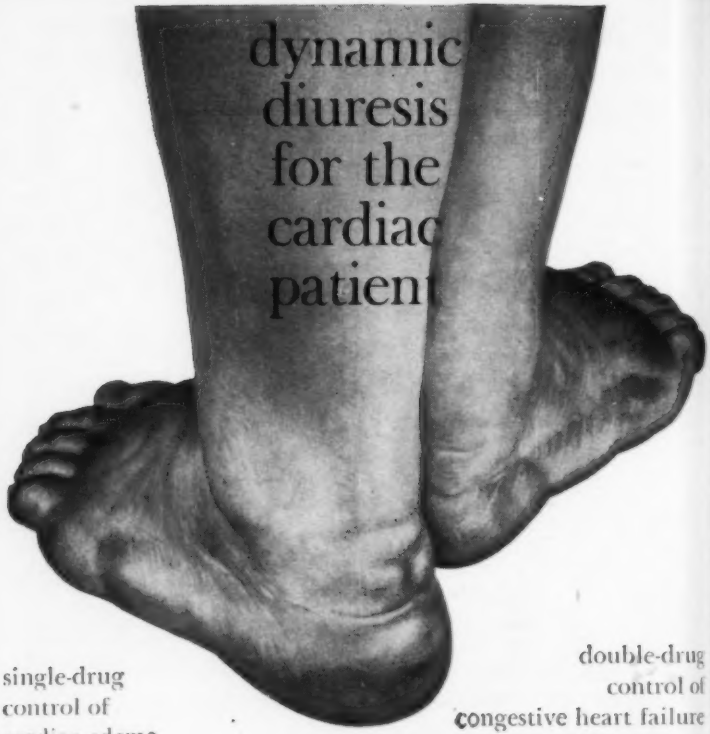

single-drug control of cardiac edema

DIAMOX mobilizes bicarbonate and with it sodium, and the fluids of edema . . . reduces water retention with no notable changes in blood pressure or electrolyte balance. One tasteless tablet each morning . . . easy to take . . . rapidly excreted . . . does not interfere with sleep.

double-drug control of congestive heart failure

DIAMOX alternated with chloride-regulating agents provides more dynamic diuresis than can any used alone . . . helps potentiate diuretic effect and counterbalance the tendency toward systemic alkalosis of chlorothiazide and mercurials . . . lessens risk of drug tolerance . . . extends intensive diuretic therapy.

Supplied: Scored tablets of 250 mg., Ampuls of 500 mg. for parenteral use and Syrup containing 250 mg. per 5 cc. tsp.

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Acetazolamide Lederle

HCO_3^- regulating diuretic

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

o asthma symptoms—In asthma, Tedral prevents bron-ial constriction and mucous congestion . . . promotes normal breathing . . . rmits greater activity. Rely on Tedral to keep your asthma patients symptom-e 'round-the-clock . . . effectively, safely *and* at moderate cost.

ge: 1 or 2 Tedral', es q.4.h. plus 1 or 2 eric Coated yed action) with regular dosage edtime.

TEDRAL®

the dependable antiasthmatic

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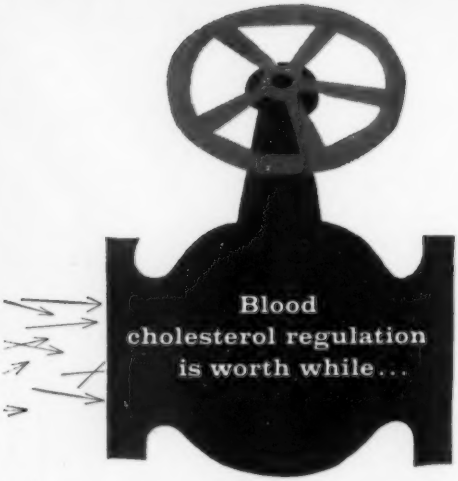

*Evidence strongly suggests that cholesterol is an important factor in atherogenesis... and investigators agree it's desirable to lower or prevent elevated blood cholesterol levels...**

Arcofac®

(ARMOUR CHOLESTEROL LOWERING FACTOR)

Arcofac lowers elevated blood cholesterol levels . . . safely . . . effectively . . . and need not impose radical dietary changes.

Arcofac supplies linoleic acid, an essential polyunsaturated fatty acid that lowers high cholesterol levels. In addition, it provides vitamin B_6, deemed necessary to convert linoleic acid into the primary essential fatty acid, arachidonic acid. Vitamin E, a powerful antioxidant, helps maintain the fatty acid in an unsaturated state.

*Amsterdam, B.: New York J. Med. *58*:2199-2212 (July 1) 1958. Panel Discussion on Proper Nutrition for the Older Age Group, J. Am. Geriatrics Soc. 6:787-802 (Nov.) 1958. Leckert, J. T.; Donovan, C. B.; McHardy, G., and Cradic, H. E.: J. Louisiana M. Soc. *110*:260-266 (Aug.) 1958.

Each tablespoonful (15 mL) of Arcofac contains:

Essential fatty acids†. . . 6.8 Gm (measured as linoleic) with 23 I.U. of Vitamin E††

Pyridoxine hydrochloride (Vitamin B_6).....1.0 mg

†Supplied by safflower oil which contains the highest concentration of polyunsaturated fatty acids of any commercially available vegetable oil.

††Added as Mixed Tocopherol Concentrate, N. F.

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A workhorse "mycin" for common infections

wide-range action

prompt, high blood levels

minimal GI upsets

CYCLAMYCIN ... potent, new Wyeth antibiotic to help you in the treatment of common infections of daily practice. It has proved effective against many pathogens including some resistant to other antibiotics ... streptococci, pneumococci, gonococci, H. influenzae, and most strains of staphylococci, especially erythromycin-resistant staphylococci. Highly stable, readily and reliably absorbed, CYCLAMYCIN produces rapid high antibiotic blood levels. CYCLAMYCIN is well tolerated ... even by some patients reacting adversely to other antibiotics. It has minimal effect on normal gastrointestinal flora ... no serious reaction problems arising from sensitivity or toxicity have been reported.

new

CYCLAMYCIN*

Triacetyloleandomycin, Wyeth

CAPSULES • ORAL SUSPENSION

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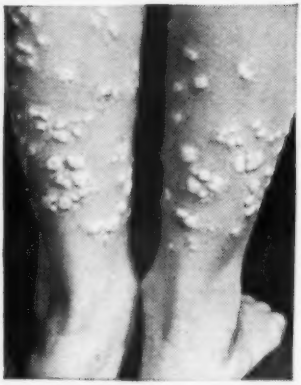
Supplied: Capsules, 125 and 250 mg., vials of 36. Oral Suspension, 125 mg. per 5-cc. teaspoonful, bottles of 2 fl. oz.



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◀ *distressing*
to the patient

◀ *perplexing*
to the doctor

RIASOL®

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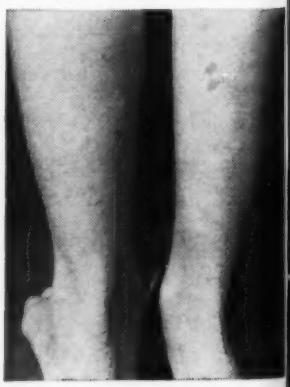
safe and effective ▶

easy to use ▶

maximum assurance ▶
against recurrence and adverse reactions



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'Troph-Iron' not only gives a healthy boost to appetite, but also promotes growth and corrects nutritional iron deficiency in children who are underpar.

The dosage? Just one tasty, cherry-flavored teaspoonful (5 cc.) a day.

TROPH-IRON® Liquid

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Also available: 'Troph-Iron' Tablets.

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Establishing the Value of Ultrasonics in Physical Medicine

Results of ultrasound therapy in acute cases have been reported as "amazing" and "astounding" and chronic cases, while not as dramatic, respond in many instances where all other methods fail.

With more than 20,000 physicians (one out of seven active practitioners) now using ultrasound in the treatment of disabilities ranging from asthma[1] to ankle sprain,[2] it may be well to review the progress that has been made in this relatively new field and to delineate the method by which its value has been established.

THREE-YEAR STUDY

First experiments in the use of ultrasound in medicine began with Pohlman in Berlin in 1938 and after World War II many laboratory and clinical experiments were made by researchers in the United States and abroad. In 1950, 25 machines capable of producing accurately controlled ultrasound, together with the necessary accessories for application, were built by the Birtcher Corporation and donated to 20 Physiatrists and Orthopaedists in hospitals including a number of medical schools. The users were to publish their findings without any commitment to the Birtcher Corporation. Three years later, after scores of published reports had indicated that ultrasonics was of definite value in some conditions and a major adjunct in others, the first commercially produced Birtcher *Megason* units were offered to the medical profession.

RESULTS REPORTED

Since that time specialists and General Clinicians have widened the application of US by daily trials on conditions which have failed to respond to ordinary therapy. Workers have reported outstanding results in more than 3,000 published papers. Osteoarthritis,[3] sinusitis,[4] epicondylitis,[5] bursitis,[6] phantom limb pain and reduction of scar tissue[7] have frequently responded amazingly to a single treatment. Local as well as nerve-root paravertebral approach has favorably influenced spondylitis, scleroderma, stomach ulcers and sympathetic reflex dystrophy.[8] Therapeutic results obtained by US energy have been ascribed* to several local reactions within living tissue: a) increased vascular and fluid circulation, b) an increase in cell membrane permeability provoking organic exchanges and osmosis, c) reactivation of previously impaired conductivity of cerebrospinal fibers and d) an increase in the pain threshold and a break in the pain cycle.

An ultrasonic treatment with the *Megason* requires only a few minutes with a hand-held transducer applied locally and to the nerve roots supplying the area. The technic can be learned quickly by the physician or his nurse.

An explanatory booklet, "Ultrasonics in a Nutshell," with abstracts from many published reports, prepared by the American Institute of Ultrasonics in Medicine, is available from The Birtcher Corp., Dept. ME459B, 4371 Valley Blvd., Los Angeles 32, California.

[1]Matlin, E.: Med. Times, Vol. 83 (Aug.) 1955. [2]Aldes, J. H.: Proc. Am. Inst. Ultrasonics in Medicine 4th Yr. Aug. 1955. [3]Schwartz, F. F.: J. of Med. Assn. State of Alabama, Jan. 1953. [4]Edmundson, F. B.: Proc. Am. Inst. Ultrasonics in Med. 4th Yr. Aug. 1955. [5]Aldes, J. H.: Ibid. [6]Toback, B. M.: Rev. of Podiatric Research, Vol. 2, No. 1 (1955). [7]Rubin, David and Kuitert, J. H.: Archives of Phys. Med. July 1955. [8]Private communication to the author. *By Dussik, Stuhlfauth, Woeber, Busnel, Gligorijevic and others.

WIDE AWAKE TRANQUILITY

Quiactin for quieting

(oxanamide)

(one 400 mg. tablet q.i.d.)

QUIACTIN provides greater tranquility, yet avoids the drowsiness that causes patient discomfort or oversteps the bounds of safety.[1] Work, and other normal activities, continue with no drop in efficiency.[2] Structurally, QUIACTIN is a glycidamide . . . atom by atom, a completely new tranquilizer, prolonged in activity, nontoxic, noncumulative and free of withdrawal symptoms. QUIACTIN will not deepen depression if it is present.

1. Proctor, R. C., Southern Psychiatric Assoc. Meeting, October 7, 1957. 2. Feuse, C. D. and Gragg, L. Jr.: Dis. Nerv. Sys. *18*:29; 1957.

TRADEMARK: QUIACTIN®

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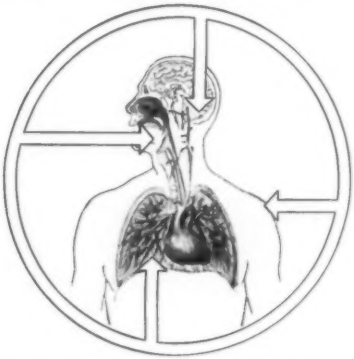
SINCE 1828

THE WM. S. MERRELL COMPANY
New York · CINCINNATI · St. Thomas, Ontario
Another Exclusive Product of Original Merrell Research

Now—All cold symptoms can be controlled



• Provides Triaminic for more complete, more effective relief from nasal and paranasal congestion because of systemic transport to *all* respiratory membranes —without drawbacks of topical therapy.†

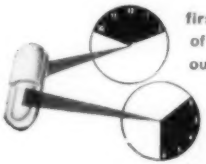
• Provides well-tolerated APAP (N-acetyl-p-aminophenol) for prompt and effective analgesia and antipyresis to make the patient more comfortable.

• Provides Dormethan (brand of dextromethorphan HBr) for non-narcotic antitussive action on the cough reflex center in the medulla—as effective as codeine but without codeine's drawbacks.

• Provides terpin hydrate, classic expectorant to thin inspissated mucus and help the patient clear the respiratory passages.

†Lhotka, F. M.: Illinois M. J. 112:259 (Dec.) 1957. Fabricant, N. D.: E. E. N. T. Monthly 37:460 (July) 1958. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958.

6 to 8 hours of relief from a single tablet t.i.d. because of this special timed-release design . . .



first—3 to 4 hours of relief from the outer layer

then—3 to 4 more hours of relief from the inner core

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Also available as palatable Tussagesic Suspension

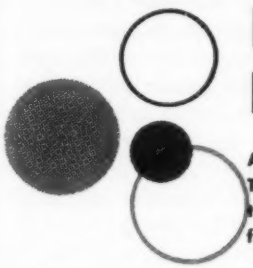
*Contains **TRIAMINIC** to STOP *running noses* and *open stuffed noses orally*

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska • Peterborough, Canada

Medical Economics

INDEPENDENT NATIONAL BUSINESS MAGAZINE FOR PHYSICIANS, APRIL 27, 1959

Holes in Your Life Insurance Program?



Ask yourself these eight questions. They'll help you spot the things that could cause you and your family plenty of grief

BY RALPH G. ENGELSMAN

Are there any hidden bugs in your life insurance coverage? It takes only a few minutes to get the answer. And those minutes may be worth a lot of money to you and your heirs.

Every two years or so, it'll pay you to take the following self-test. Try it right now and see if it doesn't spotlight something you ought to ask your agent about. Remember that it costs you nothing to fill most life insurance loopholes. But if they remain unfilled, they can cost your family a lot.

Ready? Here are the key questions:

1. How much life insurance do you really own?

If you can rattle off the exact amount without checking, you're one man in a thousand. It may be a good deal more than you imagine. Or it may be less.

It could be more, for example, if you've overlooked some group coverage you have, or an old

THE AUTHOR, *an independent consultant to life insurance companies and banks, is co-editor of the insurance newsletter "Probe."*

paid-up policy, or a lapsed policy being continued under extended term provisions. Conversely, you may have a lot less insurance than you think if you've borrowed on a policy and haven't repaid the money. The amount of any such loan will be subtracted from the death benefits due your heirs.

2. Do you have enough coverage to meet your family's needs?

If you died tomorrow, your widow should be able to clear away the expenses of your estate, to raise your children until they've finished their education, and to live in some comfort for the rest of her life. Would the policies you now own, combined with your other assets, do the trick? And if you live, will the cash value of those policies provide a running start toward adequate retirement income?

The kind and amount of coverage you need change so much as you grow older that an insurance program drawn up ten years ago may be all wrong today.

3. Will the right persons actually collect your insurance?

They may not, for example, if you've named only a primary beneficiary and if he dies in a common disaster with you. If that should happen, there's no telling where your insurance money might wind up.

Not long ago, a New England physician and his wife were involved in an auto accident. The doctor died instantly. His wife, who was the beneficiary of his insurance, died a few days later. Result: At the doctor's death, the insurance money belonged to his widow. Since they had no children, it then went into her estate, to be distributed among her family. The doctor's parents were dependent on him for support; but they got nothing.

How to avoid this sort of thing? Name contingent beneficiaries in your policies. Or, if you've already named them, be sure the list is still up to date.

One physician I know has just realized that his parents, both long dead, are still listed as the beneficiaries on one big policy. Another man recently discovered that his two oldest children would split a $50,000 policy—and that a child born after he'd bought the policy would get nothing. Still another has found that one of his policies is still payable to an old flame of his bachelor days, a girl he hasn't seen for years.

Don't assume (as some of

hese doctors did) that you can ight such wrongs through your ill. That won't work. You'll ave to get in touch with your gent or insurance company and ave the names of beneficiaries hanged on the policy itself.

4. How much insurance money will your heirs really get?

The face amount of your policies? Maybe not. Death benefits from life insurance are exempt from income taxes, but not from Federal estate taxes. If your estate, including the insurance, amounts to more than $60,000 (or $120,000 if you take advantage of the marital deduction), the Federal Government will want its slice. And your state may also grab a share.

To avoid Federal estate taxes, consider making someone else (your wife, say) the owner of your policies. Under present law, if the person whose life is insured doesn't actually own the policy, the death benefits aren't taxed in his estate.

And to avoid state inheritance taxes, be sure your insurance is payable to a named beneficiary

TRY THESE ON YOUR OFFICE DOORS

Once the typical doctor practiced in a two-room suite. Today he needs four or five rooms, and many a medical suite contains six or eight or ten. With all those doors, how can patients be sure which room is which? How can the staff be sure what's going on inside? Some practical answers:

¶ Use identifying doorplates or room numbers to help patients find treatment rooms, lavatories, etc. Or paint the doors different colors: for example, tan for consultation rooms, blue for treatment rooms. The receptionist can then ask patients to go down the hall to "the first tan door on the right."

¶ Consider installing small signal lights at each examining-room door. Hand-operated by doctor and nurse, they show when the patient is ready for an examination, when the doctor is with the patient, and when the room is free. The receptionist can then route traffic accordingly. END

—not to your estate. In most states, a stipulated portion of insurance money that goes directly to a named person is tax-exempt.

5. Is there a chance that your heirs' insurance benefits will be attached?

Almost all the states have laws exempting life insurance from creditors' claims *under certain conditions*. For example, some states exempt policies payable to close relatives or dependents. Others exempt all policies payable to anyone other than the insured's estate.

Then, too, some state laws exempt all insurance proceeds from creditors' claims; others, only a limited amount.

So you'd better check with your insurance agent on the laws of your state. You can then take steps to make sure your money goes to your family, not to your creditors.

6. Have you given the companies proof of your age?

No such proof was probably demanded when you bought any of your policies. But before a company pays out death benefits, it may ask for proof of the insured's age. If your beneficiary can't comply right away, the benefits will be delayed. And if the age listed on a given policy is wrong, the proceeds may be reduced.

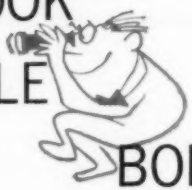
I know of one doctor who said he was 36 when he bought a large insurance policy. Actually, his "insurance age" was 37; that is, he was closer to 37 than to 36. When he died, many years later, the company found the error and scaled the death benefits down to the amount his premiums would have bought if he had given his correct age at the outset. The doctor's widow got about $3,000 less than she'd expected.

To forestall any such disappointment, you'll do well to keep some proof of your age with your insurance policies. Then there will be no delays and no questions raised after your death.

7. Are any of your policies unnecessarily rated up?

Your premium dollars may be pouring out through this loophole if any policy was rated up for occupational or health reasons when you bought it. One New Jersey physician recently came across a contract he'd bought while still a medical student. At that time, he'd had a part-time job as a bartender—which meant [*More on 232*]

DON'T OVERLOOK CONVERTIBLE BONDS



Good convertibles offer the safety of bonds, the growth potential of common stocks. But what is a 'good' convertible? Here's your answer

BY HUGH C. SHERWOOD

In late 1957, when the stock market went into a serious decline, many investors took quite a beating. For example, common stock of Thompson Products (now Thompson Ramo Wooldridge) plummeted from 73 to 42 during an eight-month period. If you'd bought 100 shares at the high and had had to sell at the low, you'd have lost over $3,000.

But if you had owned Thompson's convertible bonds instead of its stock, you'd have ridden out the storm. When the stock sold at 73, the bonds sold at 113 (which is the stockbroker's way of saying that a $1,000 bond is selling at $1,130). While the stock was falling to 42, the bonds never sold at less than about 104. And when the stock finally climbed back to near its former high, the bonds had a price tag of about 125.

In other words, during the summer and fall of 1958, the stock just about recouped its loss. But the bonds recouped their slight slide in price fully—and then some.

If you believe that today's market is too high and that another decline is bound to occur,

you may want to consider convertible bonds like those sold by Thompson. In a bear market, good bonds aren't apt to suffer nearly as much as comparable stocks.

If you expect that common stock prices will continue to rise, the convertibles are still worth thinking about. For the good ones will appreciate right along with their companies' stock issues.

But what is a "good" convertible? Before answering that question, let's review convertibles in

Ten Well-Known Con

AMONG THE BEST-KNOWN convertible bonds are those listed here. The Carrier, Chance Vought, and El Paso offerings are traded over the counter. All the rest are sold through the New York Stock Exchange's bond market. The list has been compiled by the investment advisory firm of R.H.M. Associates, New York City, which specializes in studying such issues. The listing does not necessarily constitute a recommendation to buy the bonds. Nor should bonds that are not listed necessarily be considered unattractive.

Name of Bond	ch $100 Conve
Boeing Airplane 4½s-'80	tock sh
Burroughs Corp. 4½s-'81	67 till
Carrier Corp. 4⅛s-'82	till 2/
Chance Vought 5¼s-'77	till 7/
Dresser Industries 4⅛s-'77	18 till
El Paso Natural Gas 5¼s-'7	57 till
RCA 3½s-'80	ll mat
Sinclair Oil 4⅜s-'86	38 till creasin
Standard Oil (Ind.) 3⅛s-'8	74 till
Thompson 4⅞s-'82	33 till 25 till 8

Curren uther t

general. To understand why they're often dependable buys in both bear and bull markets, you have to understand exactly how they work.

A convertible bond is a regular bond with a special right: the right to convert it into a fixed number of shares of the company's common stock.

The number of shares is specified in advance for each stage in the bond's life; it may decrease slightly every few years. But the right to convert usually lasts for at least a decade, and often

Convertible Bonds

ch $100 of Bond Value Convertible Into:	Recent Price	Call Price	Estimated Investment Value	Current Yield*	Recent Price of Stock
tock shares till maturity	117	105.00	88	3.85%	43
67 till maturity	125	104.12	99	3.60	42
till 2/1/67	106	104.95	92	3.89	44
till 7/1/67	112	104.65	95	4.69	41
18 till 3/1/67	111	103.87	93	3.72	42
57 till 8/31/67	121	104.95	104	4.34	36
ll maturity	121	105.00	87	2.89	56
38 till 12/1/61; reasing till 1986	117	104.37	101	3.74	65
74 till 10/1/62	116	102.50	86	2.69	48
33 till 8/1/62; 25 till 8/1/67	120	104.625	102	4.06	60

Current yield is obtained by dividing the current value, uther than the face value, of the bond into its interest rate.

it lasts for the entire life of the bond.

When a convertible is issued, it has the same basic qualities as any regular bond. It has a *face value*—almost always $1,000. It also has a *maturity date*—a date at which the company will redeem the bond at its face value, no matter at how low a price it may have sold in the meantime. And it pays a *fixed rate of interest* based on the bond's face value rather than on its market value.

It's these last two characteristics that give a particular convertible the name it's known by. Thus, the bonds issued by Thompson Products are known as Thompson's convertible 4⅞s of 1982. This simply means that each $1,000 bond will pay annual interest of 4⅞ per cent until it matures in 1982.

Since it *is* a regular bond in

most respects, any convertible has the following additional advantage: If the issuing company is liquidated, it must pay off the owners of convertibles before paying stockholders. Because of this—and also because of its fixed interest rate and redemption date—a good convertible bond largely resists a general decline in stock prices.

So it's apt to act like a bond in a bear market. And in a bull market, it's just as apt to act like a stock. Why? Because of its convertibility into common stock. If the stock goes up, the convertible will also rise in a way that a regular bond won't. To illustrate:

In March, 1958, the common stock of the Brunswick-Balke-Collender Company sold at about 40. At that time, the company issued some convertible debentures that sold at about 110.* Their interest rate was considerably higher than the stock's return in dividends. And, since they were bonds, they were obviously a safer holding if the stock price were to decline.

But the stock didn't decline. In the next seven months, it skyrocketed to 73. And the convertible went right along: It soared from 110 to 178.

Simple arithmetic shows why it *had* to go that high. For each $1,000 in face value of the convertibles, the owner was entitled to 24.39 shares of common stock, if he chose to exercise the conversion privilege. And 73—the price each share of stock reached—times 24.39 equals about 1,780. That's 178, as bond prices are expressed.

*A debenture is one type of bond. Since the distinction between bonds and debentures has no bearing on this article, the terms are used interchangeably here.

Why Convertibles?

Why does a company issue such attractive two-way securities? It does so for one or more of the following reasons:

¶ It may need to borrow money at a time when regular bonds might seem insufficiently attractive to potential purchasers. Convertibles have a built-in sales appeal.

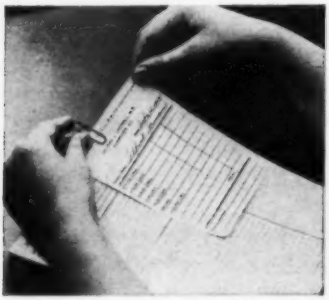
¶ It may want to sell common stock as inexpensively as possible. For a variety of reasons, it's cheaper to issue convertible bonds than new stock. (Later on, as we'll see, the company may be able to force the bonds' owners to convert them.)

¶ It may want to avoid making dividend pay- [*More on 222*]

Showing the Patient

What He's Paying For

The steps by which you can convey fee information to your aide and to your patients are illustrated here



1. THE SECRETARY STARTS *the charge slip on its rounds. She keeps a pad of slips at her desk. Before a patient sees the doctor, she writes his name and the date on a charge slip. Then she attaches it to his case-history form, as shown here.*

2. THE DOCTOR RECEIVES *the charge slip and the case history before he sees the patient. This procedure can be followed even on hospital and house calls; the secretary simply makes up the necessary forms in advance of such visits.*

Is it possible to tell patients what you're charging them without saying a word? Is it possible to itemize subsequent statements without taking extra time? Yes, it is—though the most feasible method still hasn't caught on with most medical men.

This method is the charge-slip method. And physicians who are not now using it may well give it serious consideration.

The charge slip (or routing slip, as some prefer to call it) is a simple printed form that measures, say, 4″ x 6″. It has spaces in which to write the patient's name, the services rendered him, and the charges for those services.

How do you use the charge slip as an aid to itemizing? The accompanying photo sequence tells the story in step-by-step detail.

3. THE DOCTOR NOTES *the services rendered by means of check-marks at the end of the visit. He also itemizes some services by name. He may even write in the fee himself; but in routine cases, the secretary can do this later.*

4. THE DOCTOR HANDS *his office patient the charge slip when the consultation or treatment is finished. He accompanies it with some such request as: "Would you mind leaving this with the receptionist on your way out?"*

More▶

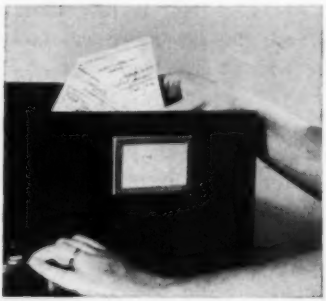
SHOWING HIM WHAT HE'S PAYING FOR

5. THE PATIENT SEES *an itemized report of the services he's received, including injections given, drugs furnished, and laboratory tests made. En route to the secretary's desk, he has an opportunity to study the details.*

6. THE SECRETARY COMPLETES *the man's charge slip by writing in the appropriate fees (if the doctor hasn't) and the date and time of the patient's next appointment (following any instructions the doctor noted on the charge slip).*

7. THE SECRETARY SHOWS *the completed charge slip to the patient, pointing out (among other things) the total amount due. This lets the patient know exactly "how much" and "what for"—and often encourages him to pay cash.*

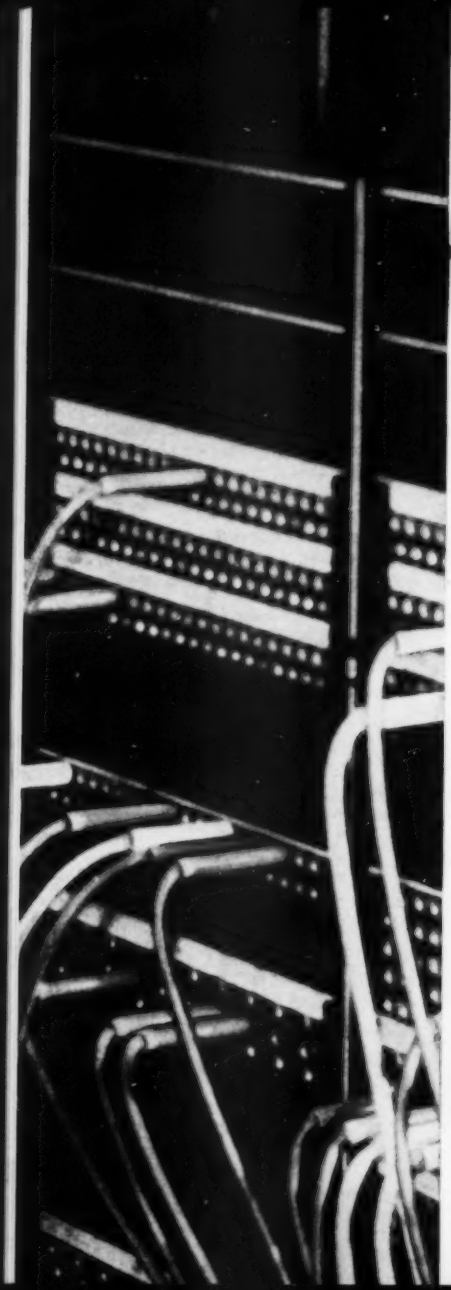
8. THE SECRETARY TRANSFERS *the amounts shown on the charge slip to the patient's financial record. If the patient hasn't already paid, the charge slip is filed directly behind his financial card until the end of the current month.*



9. THE SECRETARY GETS *the charge slip out of the financial file at the end of the month, when it's time to type up statements. Instead of itemizing the statement itself, she need only attach the original charge slip to it. There's no extra typing to be done.*

10. THE PATIENT RECEIVES *his original charge slip stapled to the statement sent him. This reminds him of the specific services rendered—and thus answers questions he might otherwise have about the bill. The usual result: prompt payment.*

END



How Good Is Yo

Dr. Albright, a general surgeon, had lined up two other surgeons to cover his practice during a long-awaited week-end of skiing. Then, with his family ready to go, both colleagues telephoned their regrets. One had the flu; the other was laid up with an acute bursitis.

Whom could he get at this last minute? Outside, his impatient son honked the horn. So the doctor, equally impatient, decided to do what a number of local physicians did all the time: He phoned the manager of the Physicians Answering Service and dropped the problem in her lap.

"Mrs. Harrold," he said, "you've got Dr. Holly and Dr. Crane down to cover me this week-end. They can't make it. So if any of my patients call, just get them someone on the available list. I'm signing out right now. Thanks a lot."

Late that night, one of Dr. Al-

THE AUTHOR *practices internal medicine in Bangor, Me.*

Is Your After-Hours Coverage?

Here's what can go wrong when you're out of touch with your patients for a few hours or a week-end. Here, too, are some tips on how to keep covering arrangements trouble-free

BY MASON TROWBRIDGE JR., M.D.

bright's patients suffered an acute intestinal obstruction. The patient's wife dialed the surgeon's number—and got the sleepy girl who was working her first night shift alone at the answering-service switchboard.

The girl reported the absence of Dr. Albright and said she'd try to get another doctor. She got one. But she gave him a wrong address. It took indignant calls from both the woman and the physician—and it also took a long time—to get the two together.

When the substitute doctor reached the bedside, he found there wasn't much he could do for the patient. Immediate and fairly complex surgery was called for—and the substitute was an internist!

He got an ambulance as fast as possible. There were more delays before a surgeon could be reached. Eventually the operation was performed, and the patient pulled through. But the patient never again called on Dr. Albright.

In a way, Dr. Albright was lucky. He merely lost a disgruntled patient. Bad after-hours coverage *can* be construed as abandonment, however, and thus can easily lead to malpractice action.

What's the best way to protect ourselves against bad after-hours coverage? I'd say it boils down to reminding ourselves repeatedly of the main things that go wrong. So I've compiled a list. Here it is, along with some possible correctives drawn from my

own experiences and those of my colleagues:

1. Sometimes the answering service is given more responsibility than it can handle.

From all I hear, most answering services are pretty dependable. When they do go wrong, as in the case of Dr. Albright, it's often the doctor's fault.

Even an inexperienced girl at the switchboard can do an adequate job if the absent doctor has left exact instructions. But if he has told the girl to get "anyone you have on the available list," there's always a chance she'll call a dermatologist or a psychiatrist for one of his postsurgical patients.

"You talk to the doc, Raif, while Ah siphon out his gas."

Probably most doctors who take chances this way do so for only a few hours. But they're still taking chances. Example: a pediatrician who likes to go to the movies occasionally. He doesn't like to ask a colleague to cover him for such a short time. So he signs out to the answering service with no cover. Recently, while he was out, one of his patients had convulsions. The mother just about had the same when the operator said *she'd* have to get another doctor.

Then, too, some men sign out with: "I don't want to be called unless there's an emergency." Thus they leave it up to the girl on the switchboard to decide between emergency calls and merely urgent ones. If this isn't delegating too much responsibility, what is?

The corrective? It's not only giving more exact instructions; it's also keeping in mind the next point:

2. Often the answering service is taken too much for granted.

Some slip-ups are probably inevitable. But it doesn't pay to tolerate those that stem from some inherent defect in the answering-service's organization.

Watch out especially for an understaffed service. The symptoms: frequent busy signals, or else "One moment, please" followed by a long silence—or even a disconnection—as the operator attempts to take care of prior calls.

Watch out, too, if the service handles calls for commercial enterprises such as taxi companies and oil suppliers. Its switchboard can really get in a snarl when, on a snowy winter morning, people want cabs, need depleted oil-tanks filled, and must talk to the doctor about Tommy—all at the same time.

Another symptomatic snarl can be one in the operator's voice. In your patients' view, this can reflect on you. So can the cold, brisk voice of an operator to whom you (and hence your patients) are just another commercial customer.

Better keep an ear cocked for such harmful sounds. And while you're at it, better ask yourself whether you really want the operator to answer with "Dr. Jones' office." Most callers soon discover it's not the office. Which can make you, the doctor, seem a trifle sneaky.

Well, that's one problem easily solved—by having the girl

say frankly: "Dr. Jones' answering service." But what about the other answering-service problems?

I've heard of a number of solutions. Many doctors make a point of calling the service for messages the minute they're back on the job; they never wait for the service to call them. This seems an excellent idea. One G.P. started doing this after patients on two occasions called him in the afternoon to see when he'd be able to respond to their messages of the night before!

Many other doctors test the answering service occasionally to see if it's on its toes. On one such check, a doctor dialed his number and then counted thirty-two rings without an answer. "I was damned mad," he says. "I hate to think how a patient would have felt."

Another doctor rang and rang *his* office number before the phone was eventually answered —by his cleaning woman.

If such tests make it clear that all isn't well with the answering service, what then?

Well, we can raise hob with the management, or change to another service, or even start our own service, by golly. Doctors have done it in several localities. For instance, sixty doctors have their own exchange in East Orange, N.J. It operates around the clock and, I'm told, gives first-rate service.

As apparently do most answering services everywhere. Let me emphasize that the foul-ups I've described above are simply the kind that *can* happen.

3. Responsibility for covering isn't always pinned down to one man.

Is it really a good idea to leave a list of four or five available doctors instead of arranging for coverage with one—and only one—colleague?

Some doctors feel it is. Yet the end result may be that none of the other men feels any real responsibility. When a patient needs attention, your answering service or your aide may encounter a bit of buck-passing that's hard to cope with.

It's even worse if the patient has to make the phone calls himself, using a list you've given him in person or via one of those automatic recordings in your office. The average patient doesn't like to call a strange physician. If he's forced to call several and finds none [*More on 212*]

PLAINTIFFS' ATTORNEYS

Defense counsel have discovered new ways to combat the use of gruesome medical photos, blackboard computation of damages, and other tactics used against doctors in court

By John R. Lindsey

Jury awards in malpractice cases are skyrocketing—and why? One reason is that plaintiffs' attorneys are becoming artists at playing on juries' emotions. The tactics of many such lawyers have been ably described by Arthur Merz, counsel for the National Association of Independent Insurers:

"They motivate juries to open the purse strings, not by merit of liability, but by shocking the jury with the gruesome nature of the injury. They use all the arts of Hollywood to whip people to an emotional frenzy to grant a huge amount."

Is there any defense against such an attack? Fortunately, there is, according to a prominent Philadelphia defense attor-

ney, J. Harry LaBrum. Lawyers who defend doctors in malpractice cases don't make headlines —as the six-figure-award artists do—but they're winning more battles than you may realize. They're winning, says J. Harry LaBrum, because they've learned how to fight fire with fire.

Attorney LaBrum is a former chairman of the American Bar Association's section on insurance, negligence, and compensation law. At the Vanderbilt University School of Law, he recently discussed a number of the emotional courtroom tactics used by plaintiffs' attorneys. Then he showed how defense counsel have successfully counterattacked. Here are a few of their techniques, as spelled out by Mr. LaBrum:

1. When plaintiffs' attorneys bring in gruesome enlargements of medical photos, the doctors' defenders stress that they're not true to life.

In a recent Philadelphia case, for example, a bigger-than-life-size picture presenting a close-up shot of a neck injury was brought into court. Medically, the picture wasn't very significant. But its bright reds and complex melange of veins and bones combined with its size—three feet by four feet—were bound to have a striking impact on lay viewers. The plaintiff's lawyer placed it on an easel, where it sat in plain view of the jury throughout the three days of the trial.

Here's how the defense counsel blunted its effectiveness in his address to the jury:

He paused in front of the picture, stared at it, and then said: "Ladies and gentlemen of the jury, this picture is what is known to you as a *blown-up picture*. The case you have heard the last two days and a half is what is known to us lawyers as a *blown-up case*."

Apparently, the jury got the point. It brought in a verdict for only half the amount the defense had earlier offered as a settlement.

2. When plaintiffs' attorneys put a price tag on pain, the doctors' defenders expose the method of computation.

Pointed ridicule is used to deflate what LaBrum calls "the simplest yet most effective technique used by plaintiffs' attorneys to increase the amount of the award: the blackboard tactic." This tactic (which is illegal in a few states) usually fits some

such pattern as the following:

The plaintiff's lawyer elicits medical testimony that the patient may well suffer pain in, say, his left shoulder for the rest of his life. Then the attorney asks whether the jurors would be willing to suffer such pain for as little as 50 cents an hour. He goes to the blackboard, writes down "50 cents," and multiplies it by twenty-four hours a day, seven days a week, fifty-two weeks a year, and finally by thirty years—the plaintiff's estimated life expectancy. He chalks up the total, $131,-040, in big figures; and he leaves it on the blackboard for the jury to remember.

In one recent case where such a technique was used, the defense counsel moved quickly, LaBrum recalls, "to erase the plaintiff's figures [and] write a large zero in their place. [He then explained] to the jury that since no negligence had been proved, the plaintiff was actually

"Primipara, my foot!"

not entitled to anything in the way of damages."

But the doctor's attorney really won his case by drawing a ridiculous analogy to the plaintiff's blackboard arithmetic. Asking the jurors whether they'd gladly pay $18,000 for a TV set, he wrote down the figure and said: "That's what you'd pay if you followed the same mathematical reasoning that my learned opponent has just used."

To explain what he meant, he produced a theatre ticket "priced at $2.40 for a two-hour show. That's 2 cents a minute for entertainment." On the assumption that TV shows are worth only half as much, he wrote down "1 cent." He multiplied this by sixty minutes an hour, by eight and a quarter hours a day, by seven days a week, by fifty-two weeks a year, by ten years of life expectancy for the set. The final figure: $18,018.

Evidently convinced of the sophistry of the blackboard-numbers game, the jury found for the doctor.

3. When plaintiffs' attorneys claim huge loss of earnings for a client, the doctors' defenders produce the person's income tax returns.

In one case where LaBrum served as defense [*More on 204*]

Estate planner

A good friend of mine is a hard-working, highly successful practitioner, but he's so careful with his money he's almost miserly. Recently, when he was away, his wife called me to see one of their children. Afterward she said she'd like to send me a present. I protested this was unnecessary, adding that her husband never gave me anything.

"I'm not surprised," she said. "You know what he gave *me* last Christmas? A fruitcake a patient gave *him*!"

I blurted out: "Doris, what will you ever do with all the money he's saving?"

"I don't know," she answered. "But I hope my next husband enjoys spending it." —M.D., TEXAS

Tax Benefits Of Office-Building Ownership

You can save money when you buy the property, every year you own it, and even when you sell it. Here are direct answers to the questions you may be asking

By Allan J. Parker, LL.M.

A suburban friend of mine, whom I'll call Dr. Harris, has been toying with the idea of buying a small medical office building. As he explained it to me recently, his practice has outgrown his present rented office, and this seems a good time to invest in property of his own.

"I think I could find time to give some attention to real estate management," he said. "And I think I'd enjoy owning a small place—one with three office suites, say, two of which I could rent out. But what really intrigues me is this: I've heard there are some big tax advantages to owning your own medical building. I'm a cautious fellow, though. Before I go any further, I'd like to know what the advantages are. Mind if I ask you some questions?"

When I told him to ask ahead, he shot a number of shrewd queries at me. They seemed so much to the point that I believe many other doctors might like to know the answers. So, for your information, here are Dr. Harris'

THE AUTHOR *is a New York City attorney.*

questions, followed by some carefully considered replies:

When a doctor buys a medical office building, can he deduct the closing fees on his Federal income tax return?

No, he can't directly deduct such expenses of the purchase as attorneys' fees. But he can add them to the cost of the property and can thus recover them through depreciation deductions.

But don't forget that depreciation is allowable only on the building, not on the land. So you have to allocate closing fees between the two in the purchase price. If your allocation is reasonable, the Internal Revenue Service will accept it.

Is there a tax advantage to taking title in the name of the doctor's wife?

Not if a joint income tax return is filed—the usual case. It's true that estate taxes on the doctor's death might be reduced if the property were removed from

"Spare a quarter, Doc? I got the laxative habit."

his taxable estate. But such a transfer is subject to gift taxes, which might largely offset any estate tax saving.

And there may be one big disadvantage to such a device, as I tactfully pointed out to Dr. Harris. A doctor I know lived to regret the day he placed property in his wife's name alone: Three years later, she took a quick trip to Reno.

What about taking title jointly with your wife?

Again there are no income tax savings, and usually no estate tax savings either. But there's one possibility: Some state inheritance tax laws don't tax real property jointly held by husband and wife; and a transfer of property in this manner isn't a taxable gift. So your own best answer to the question may depend on where you live.

If the doctor forms a corporation to hold and operate his building, might this bring him some tax benefits?

The answer here depends pretty much on the size of the doctor's income. Here's why:

A corporation pays taxes at the rate of 30 per cent on its first $25,000 of income and 52 per cent on the rest. So if the doctor's top tax rate is a good deal higher than 30 per cent, and if his corporation's income isn't likely to exceed $25,000, he'll probably effect tax savings by incorporating.

They'll be less than you might expect, though. Reason: Not only are the corporation's profits taxed directly, but they may also be taxed all over again when and if they're distributed to the doctor as dividends. (The law that permits stockholders to avoid this so-called double tax on corporate dividends doesn't apply to corporations that get more than 20 per cent of their receipts from such unearned income as rent.)

Incorporation may be a very good tax-saving device, however, for the physician who already enjoys a substantial dividend income from other sources. He can transfer enough of his dividend-paying stocks to the realty corporation so that only a little more than 50 per cent of its gross income will come from rents.

An "incorporated pocketbook" of this sort pays off in taxes because dividend income in the hands of a corporation is taxed at an effective rate of only about 5 to 7.5 per cent. As you know, that's a far lower rate than

the rate you have to pay as an individual.

But be careful! If you permit your realty corporation to get less than half its gross income from rent, it stops being a realty company and becomes a so-called personal holding company. Any such company is subject to a possible penalty tax of 70 to 80 per cent on its undistributed income.

What, then, is the big tax advantage of office-building ownership for a doctor who isn't extremely well off?

I can answer this question in three words: the depreciation deduction. Let's assume that your net annual income from a $60,000 building is $6,000. If you depreciate the building at 5 per cent over twenty years, your taxable income from it is cut by $3,000 a year.

Meanwhile, of course, the property may not actually depreciate in value if you keep it in good shape. In fact, you may sell it at a profit in a few years. So your depreciation deductions give you, in effect, partially tax-exempt net cash rentals.

Naturally, too, all the ordinary expenses of maintaining your building—paint, heat, electricity, necessary repairs, etc.—are allowable deductions. And if you eventually sell the property at a profit, it will be taxed at the favorable long-term-capital-gains rates.

Are there any further opportunities for tax savings when a physician sells his privately owned office building?

Yes. For instance, if he has to sell at a loss, he has this consolation: Any such loss isn't treated merely as a capital loss, which offsets low-taxed capital gains; it's considered an ordinary loss and thus may be used to offset highly taxed income from practice.

Incidentally, there's an interesting tax-saving device known as "sale and leaseback." Under this arrangement, one doctor I know sold an inherited office building at a loss, which he could deduct against his other income. He then entered into a twenty-year lease on the building.

Since he could now deduct the full amount of his own rent every year, his total tax savings were substantial. They far exceeded what he'd have saved through deducting for depreciation and maintenance had he held the property. [*More on 203*]

Are Those Low-Priced Stocks Any Good?

Financial experts say most $1-to-$15 shares are best left alone. How do you spot the others—those that stand up as interesting investments? First you find the facts behind their bargain-basement price tags. Start with these pointers

By Hugh C. Sherwood

Let's assume that in January, 1958, you felt you were adequately covered by insurance and adequately invested in well-known, well-regarded stocks. Let's assume you had another $1,500 or more that you could afford to gamble.

So you decided to put roughly half your spare cash in a high-priced common stock, the other half in a low-priced one. You bought three shares of I.B.M. at its year's low of 300 (total investment: $900). And you also bought 100 shares of American Motors at its year's low of 8 (total investment: $800).

Eleven months later, you unloaded your two stocks at prices very close to their year's highs. You sold your I.B.M. stock at

533, giving yourself a profit of $700. You sold your American Motors at 40, giving yourself a hefty gain of $3,200.

Your bank account is now richer by several thousand dollars. And perhaps you think you're a lot richer in experience

If You'd Like to Invest

Interested in low-priced stocks with speculative merit? Then you may want to look over the six listed below. For the reasons given, the Wall Street investment brokerage firm of Bache & Co. thinks they all have good potential for price appreciation, both in 1959 and over the long haul. The first three are sold over the counter. Phillips-Van Heusen and Walworth are traded on the New York Stock Exchange. Two Guys From Harrison on the American Stock Exchange.

ACME INDUSTRIES is a medium-sized concern in the air-conditioning field. It's now emphasizing sales of its own air-conditioning units instead of mainly manufacturing parts for other firms. In fiscal 1958, the firm reported earnings of $.76 per share. Because its costs are well controlled and its sales volume is expected to increase, it might well report earnings of around $1-$1.25 in fiscal 1959. Recent price: 10¼.

DANLY MACHINE SPECIALTIES is the leading mass producer of precision die sets for industry. In the past three years, it's made capital expenditures of more than $11,000,000 (over $12 a share), putting itself in an excellent position to meet future demands. In 1957, its sales amounted to $77,500,000. In 1958, they shrank to $30,600,000, which resulted in a deficit of $.10 per share. With the recession over, machine tool orders are likely to pick up, and the firm could begin to show substantial earnings. Recent price: 10⅛.

DIXON CHEMICAL & RESEARCH is a small chemical firm whose main product is sulphuric acid. Its management is young and energetic. The firm has recently expanded its capacity and plans to expand further. Because of this, and because rises in national economic activity usually boost the consumption

too. You wonder if you've used sound judgment in making most of your past investments in well-regarded but high-priced stocks. You wonder if you shouldn't put a lot more of your money—perhaps most of it—into low-priced issues. *More*▶

In a Low-Priced Stock . . .

of sulphuric acid, earnings may improve from a few pennies to around $.80 per share this year. Recent price: 10⅞.

PHILLIPS-VAN HEUSEN CORPORATION makes and sells men's shirts and other accessories. By introducing wash-and-wear shirts and by aggressively promoting its goods, it has increased sales and achieved good earnings—contrary to the trend in the industry as a whole. It has also acquired a controlling interest in Kennedy's, Inc., a New England men's apparel chain. This could give Phillips-Van Heusen an additional $5,000,000 in captive sales. In 1958, it reported per share earnings of $1.42. In 1959, they're expected to climb to better than $1.75. Recent price: 14½.

TWO GUYS FROM HARRISON operates eighteen "discount" stores, mainly in New Jersey. The management plans to open four more stores this year. Since 1954, the firm's sales have jumped 153 per cent, its earnings 193 per cent. In the fiscal year ending last August, its earnings were $1.19 per share. In the year ending this August, the earnings per share are expected to be higher. Recent price: 13¾.

WALWORTH COMPANY is a broad-line manufacturer of valves. Much of its business consists of supplying valves for the new or expanded plants of other companies. Because there was relatively little plant expansion in 1958, Walworth's earnings were low—$.37 per share. They're likely to remain low during the first half of this year because the company is incurring additional costs through the relocation of its manufacturing facilities. But in the last quarter of 1959, earnings may amount to $.70 per share. Such a trend could take them as high as $3 per share in 1960. Recent price: 14¾.

Would that be a wise plan to go on in the future? According to a recent sampling of Wall Street investment experts, the answer is: No, it wouldn't be. But, the experts hasten to add, that doesn't mean all low-priced stocks are bad buys. In fact, some are very good buys.

So let's consider the pros and cons of such issues. First, the pros:

There are two great advantages to buying stocks selling between $1 and $15 a share. One is that, for the same amount of money you'd put up to buy one or two high-priced stocks, you can buy a far larger number of low-priced issues. You can, in other words, spread your risks.

The second advantage is that you may make more money from a low-priced stock than from a high-priced one—assuming, of course, you've purchased a good issue. In a bull market, chances for a good low-priced stock's doubling or tripling fast are better than for a high-priced stock. If you hold onto it for the long term, it may do even better and pay you good dividends in the process.

From January, 1958, through January, 1959, Standard and Poor's low-priced stock index soared 89 per cent. But its regu-

"Vacation? You've just completed eleven and a half months of one!"

a specific treatment for a **V. I. P.**

your very important patient...
(and what one isn't!)

with a very important problem...
(allergy)

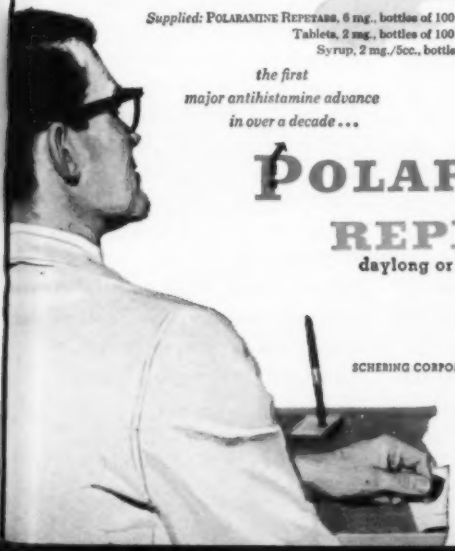
controlled by a very important product...
(Polaramine...the newest antihistamine)

The control of your patient's allergy is very important to him. He expects the greatest relief possible—and he can have it with POLARAMINE.

Until POLARAMINE, your patient had to take the antihistamine benefits with the side effects. But now POLARAMINE—*the closest approach to a perfect antihistamine*—virtually eliminates side effects and achieves a greater therapeutic effectiveness in the management of a wide range of seasonal and nonseasonal allergies at lower dosages than other antihistamines.

POLARAMINE REPETABS permit patients daylong or nightlong relief from allergic symptoms with a single medication.

Supplied: POLARAMINE REPETABS, 6 mg., bottles of 100 and 1000.
Tablets, 2 mg., bottles of 100 and 1000.
Syrup, 2 mg./5cc., bottles of 16 oz.



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in over a decade...

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dextro-chlorpheniramine maleate

REPETABS®
daylong or nightlong relief

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lar over-all stock index went up only 31 per cent. Other studies have shown low-priced issues outdistancing higher-priced issues by even more spectacular margins.

There's another point that many investors overlook: Low price isn't necessarily synonymous with low quality.

Says Walter K. Gutman, research chief for the Wall Street firm of Shields & Co.: "Unfortunately, many people regard with suspicion any stock that sells for less than $30 a share. They automatically assume there must be something wrong with it. But history shows many low-priced stocks have been very good buys."

Why Some Are Cheap

Besides, there may be a good reason why a stock is low-priced —a reason that has nothing to do with quality. There may simply be a great many shares outstanding. That fact alone accounts for a good many low price tags on common stocks of good quality.

"Compare British Petroleum and Superior Oil of California," says L. O. Hooper, research chief for W. E. Hutton & Co. "British Petroleum is the fifth largest oil company in the world. It's a thoroughly legitimate, high-quality firm. Yet it has issued roughly 200,000,000 shares of common stock. As a result, the stock sells for around $7 or $8 a share.

"Superior Oil is another large firm, although much smaller than British Petroleum. It has issued only 400,000-odd shares. The price tag on each one of these shares is about $2,000."

Reasons to Beware

But for each advantage of low-priced stocks, a disadvantage can be cited. In fact, you can find more arguments against than for such issues. Let's look at three big ones:

1. You run a much bigger risk of making a mistake when you buy a low-priced stock. As W. E. Hutton's research chief puts it: "Other things being equal, an investor will find the poorest values in low-priced issues, the best values in high-priced ones."

2. You run a bigger risk of buying a stock that's being touted on the basis of false rumors. Rumors, both true and false, crop up around the best of stocks. But they're more apt to swirl around low-priced issues,

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with a new, highly potent
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- inhibits aqueous humor formation—lowers intraocular pressure
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- smooth control—few side effects
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- economical

Indications: Chronic simple (wide angle) glaucoma; acute congestive (narrow angle) glaucoma; chronic congestive glaucoma; secondary glaucoma (acute phase); preoperative control of intraocular pressure of glaucoma.
Dosage: Usual adult dosage is from 25 to 50 mg. once to three or four times daily. Therapy with 'Daranide' is usually most successful when employed in conjunction with miotics. As with patients on any other carbonic anhydrase inhibitor, it is essential to keep a close check on the electrolyte balance of the patient during therapy with 'Daranide'.
Additional information on 'Daranide' is available to physicians on request.
Supplied: 'Daranide' Tablets, 50 mg., bottles of 100.

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many of which are of questionable quality.

Some such rumors come from boiler-room operators who call doctors and other investors long-distance—an almost certain sign that something about the offerings is fishy. Other rumors spring up right on Wall Street. A classic case of this kind occurred only a few weeks ago.

On the first Monday in February, the common stock of Park Chemical Company shot from 9⅝ to 18 in the space of a few hours. But, by day's end, it had

TRY A SUGGESTION BOX?

Suggestion boxes work well in industry. Why not in medical offices?

The thought of a box so labeled may not fit in with your ideas on professional decor. So a management firm in Waterloo, Iowa, advises offering the same opportunity to your patients by mail. It even furnishes the wording of a letter you can send them:

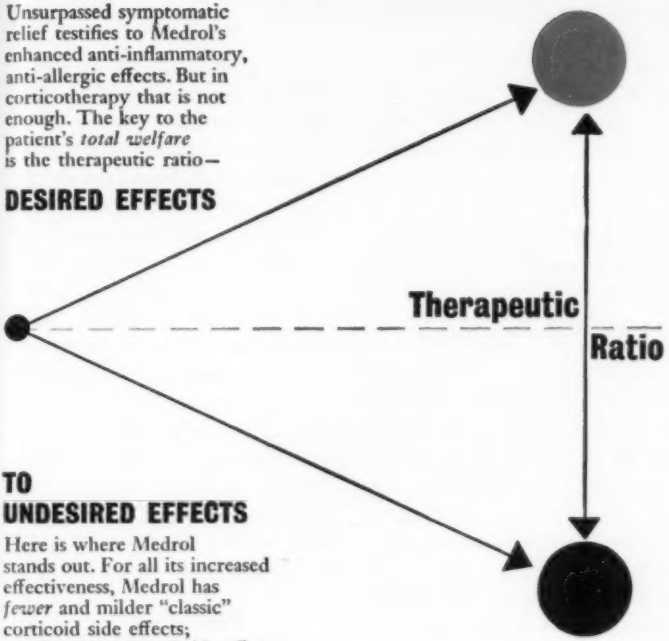
"We want to make your visits to our office as pleasant and as convenient as possible. It occurs to us that you may have suggestions to offer that would enable us to give you even better care. We realize that sometimes little things are overlooked in the rush of daily duties, little things that mean a great deal to patients. . .

"If you care to suggest any ideas for improving our office procedure, we would be delighted to hear from you. No need to sign your name—just note your thoughts on the reverse side of this letter and return it to us in the postpaid envelope enclosed . . ."

As the management firm points out, the doctor who sends this letter shouldn't expect many answers. Human nature being as it is, most people won't reply. But they will take note of the doctor's interest in pleasing them. So the power of suggestion will be at work even if the letter brings *no* helpful replies. END

Unsurpassed symptomatic relief testifies to Medrol's enhanced anti-inflammatory, anti-allergic effects. But in corticotherapy that is not enough. The key to the patient's *total welfare* is the therapeutic ratio—

DESIRED EFFECTS



TO UNDESIRED EFFECTS

Here is where Medrol stands out. For all its increased effectiveness, Medrol has *fewer* and milder "classic" corticoid side effects; *no* disturbing "new" side effects such as muscle weakness. Whenever corticotherapy is indicated, remember that Medrol has the *best therapeutic ratio in the steroid field.*

Medrol hits the disease, but spares the patient

The best therapeutic ratio in the steroid field makes

Medrol*

the choice of physicians who consider the total welfare of their patients

*Trademark, Reg. U. S. Pat. Off.—methylprednisolone, Upjohn

Upjohn The Upjohn Company Kalamazoo, Michigan

fallen back to 14¾. And by the end of the week, it was down to 11⅛.

What had happened? A rumor had got around that the chemical firm would soon market a new drug. And almost as quickly, the company denied it was even in the drug business.

Are You Vulnerable?

According to L. O. Hooper, doctors are particularly vulnerable to rumors. He says: "M.D.s talk to too many people—patients, other doctors, friends at their country clubs. And whenever they talk with those people about the market, the people brag. They recount the investments they've made that have panned out, the hot tips they've gotten, the important developments that are sure to occur. They rarely talk about the money they've lost."

3. You run a bigger risk of buying a stock that's overpriced. True, the issue you consider may be low-priced. But that low price tag may still be much too high in view of the issuing company's earnings and prospects.

The fact is, the general public prefers low-priced stocks. For every investor who automatically casts a jaundiced eye on low-priced issues, there are several who look for them eagerly.

So what happens? According to Standard & Poor's research chief, Edward Donahue, "Investors buy and buy and buy low-priced stocks. In the process, they bid the stock prices up. And in terms of present and prospective earnings, many of the issues come to be the most expensive you can find."

It isn't just that you may pay more than a given stock is worth. If there's a sharp reaction or if investors suddenly lose confidence in the stock, it may tumble farther and faster than it rose.

Play It Safe!

There, in a general way, you have some of the major pros and cons of low-priced stocks. Which should you side with? Generally speaking, with the cons, say the investment experts.

Their advice boils down to this: The wise doctor will put most of his investment money in blue chips and reliable growth stocks. But if he wants to take a chance on a low-priced issue, he begins by making sure the company is thoroughly legitimate.

Is it listed on one of the major

dieting is

TORTURE

Photo by Weegee

The patient complains: "I feel nervous, irritable, tense, miserable and depressed from my diet. Maybe I should just stay fat because DIETING IS TORTURE!"

for the patient who can't stay on a diet prescribe the diet but add

Obocell® TF

Obocell TF (tension formula) contains an antidisturbant, methapyrilene, to help the obese patient endure a strict diet. Methapyrilene is not a barbiturate, does not produce barbiturate side effects. Obocell TF combines this antidisturbant with *d*-amphetamine phosphate to curb the appetite and provide a "controlled lift" eliminating possible CNS overstimulation. Thus Obocell TF suppresses the appetite and, in addition, controls bulk hunger with Nicel. It can be given in the evening to combat the night-eating syndrome without disturbing sleep.

Each Obocell TF tablet contains:

Methapyrilene, an antidisturbant	25 mg.
d-amphetamine phosphate (dibasic)	5 mg.
Nicel, non-nutritive, hydrophilic agent	150 mg.

For Rx economy prescribe Obocell TF in 100's.

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Decatur, Illinois

exchanges? Some good firms are not listed. But, generally speaking, a listing is at least one indication of integrity.

It also makes sense to check the number of shares a given company has issued. If the number is very large, that may largely account for the stock's low price. And, of course, you'll want to look at the industry the company is in, its competition, its assets, its earnings, its management, and other pertinent factors.

You needn't be too concerned if its dividends are small. And you needn't worry too much about past earnings if current profits are on the upswing. But, by and large, you should consider the same factors and give them the same weight as you would in deciding on any other stock.

Hunches Can Help

Next, use your intuition to size up probable future developments. Says Shields' Walter K. Gutman: "*Somebody* once foresaw the popularity of Scotch Tape. The wise investor looks for new products that will fill a big need. A new development means more to a firm with a low-priced stock than it does to a firm that has a higher-priced issue."

Finally, before you actually put money in a given low-priced issue, ask your broker about it. He may agree with your selection. Or he may know of another low-priced stock that looks as if it's headed for big things. Although he may be wrong, he usually has a better chance of being right than you do. (For an example of what one investment house likes among low-priced stocks, see the listing on pages 96-97.)

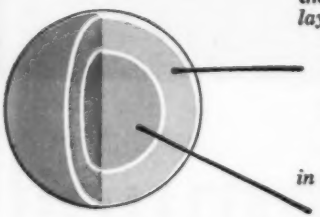
He Scorns Doctors

That last bit of advice is particularly important. Says one Wall Street man: "I've talked with many doctors about stocks and bonds. And I've discovered that the typical doctor has no flair for investing. He isn't even versed in the language of the market.

"If a doctor wants to invest in a low-priced stock once in a while, let him ask his broker for help. You can't really analyze these things unless you take plenty of time messing around with background information. And how many American physicians have that much spare time?" END

he complaint: "nervous indigestion"

diagnosis: any one of several nonspecific gastrointestinal disorders quiring relief of symptoms by sedative-antispasmodic action with ncomitant digestive enzyme therapy. **the prescription:** a new formu- ion, incorporating in a single tablet the actions of Donnatal and ntozyme. **the dosage:** two tablets three times a day, or as indicated.



the formula: *in the gastric-soluble outer layer:*

Hyoscyamine sulfate	0.0518 mg.
Atropine sulfate	0.0097 mg.
Hyoscine hydrobromide	0.0033 mg.
Phenobarbital (1/8 gr.)	8.1 mg.
Pepsin, N.F.	150 mg.

in the enteric-coated core:

Pancreatin, N.F.	300 mg.
Bile salts	150 mg.

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Kenacort safely starts your patients off right — with all the benefits of systemic corticosteroid therapy and few side effects to worry about. Increased corticoid activity is provided on a low dosage schedule[1-3] without edema,[1-4] psychic stimulation,[1-3] or adverse effect on blood pressure.[1-3,5] A low sodium diet is not necessary.[4,5] Gastrointestinal disturbances are negligible[2,4,5] with less chance of peptic ulcer.[4] This makes Kenacort particularly valuable in treating your "problem patients" — such as the obese or hypertensive and the emotionally disturbed.

Supplied:
Scored tablets of 1 mg.
Bottles of 50
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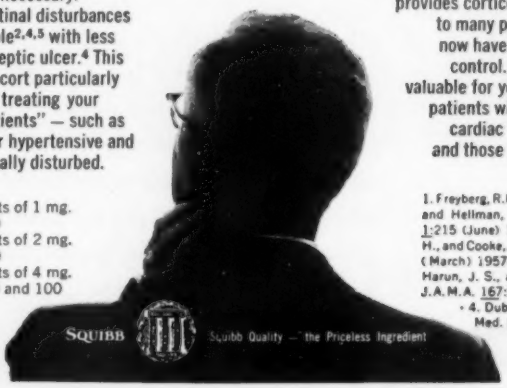
for patients with dermatoses requiring corticoids

Kenacort, particularly in treating inflammatory skin conditions, has proved effective where other steroids have failed. It quickly alleviates itching, erythema, and irritation with its enhanced antiallergic, anti-inflammatory and antipruritic activity. Because of its low dosage[1-5] and relative freedom from untoward reactions,[1-5] Kenacort provides corticosteroid benefits to many patients who until now have been difficult to control. It is particularly valuable for your dermatologic patients with hypertension, cardiac disease, obesity and those prone to psychic disturbances.



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How I Lost Patients— And Then Won Them Back

Formality doesn't pay, but friendliness does, this young doctor says. And he proves his point from unique and tragic experience

BY BURTON H. FERN, M.D.

"All patients are potential bastards," a colleague once said to me.

"No," I countered. "All patients are potential friends."

I wasn't trying to be Pollyanna. I'd learned the hard way how true my statement was—how each patient's friendship means each patient's loyalty, and how such loyalty builds a practice, increases collections, and makes for better medicine.

When I began the private practice of pediatrics, I took over a practice that had kept two pediatricians on the run. At first, my waiting room was bursting at the

ABOUT THE AUTHOR: *Now disabled by polio, 33-year-old Dr. Burton H. Fern of Stratford, Conn., can no longer carry on the active practice of medicine. But he writes a weekly newspaper medical column as well as magazine articles. "Instead of advising one patient at a time, I now advise thousands," he says. This article has won him one of the 1958* MEDICAL ECONOMICS *Awards.*

seams, and many newborns at the local hospital wore wristbands identifying them as my patients.

But gradually my popularity waned. At the end of three months, my waiting room was empty, and I had little reason to visit the newborn nursery.

What had I done wrong? How had I managed to tear down the practice instead of building it up?

He Didn't Unbend

A young medical secretary supplied the answer. "Patients want to think you're their friend," she said. "But you act too formal to be friendly. So the patients go elsewhere." (As you know, we pediatricians often use the word "patient" for parents, especially mothers.)

Raised and trained in a big city where doctors usually discussed only professional matters with patients, I'd assumed that I *should* act formal in practice. I didn't want to be accused of prying into patients' private affairs. So I limited my conversations to talk about the child and his illness. That way, I thought, I wouldn't appear "unprofessional."

Actually, I'm far from standoffish by nature. I'd have liked to engage in small talk with people and to learn the latest town gossip. But I was afraid to let down my professional front.

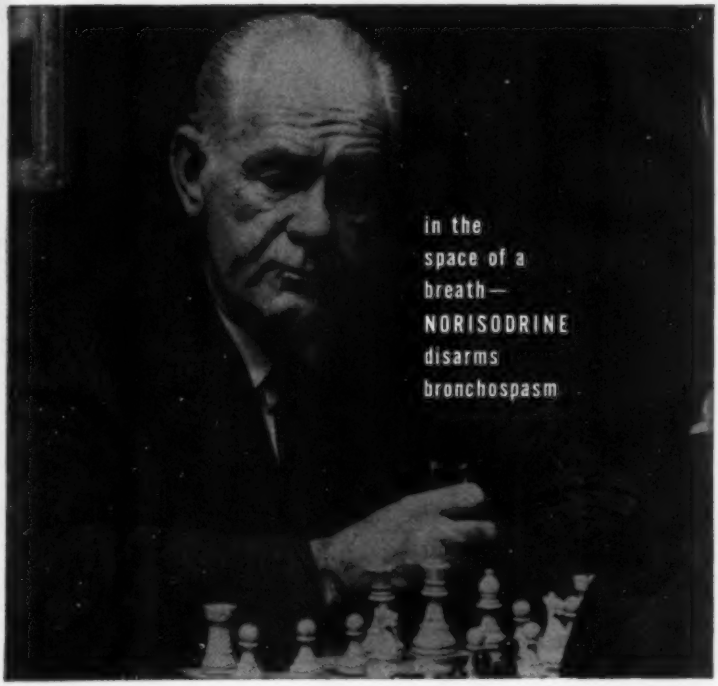
The Natural Way

Now I dropped the front and became myself. A doctor doesn't have to be coldly formal to give first-rate care, I reasoned. I began to enjoy each patient as a person and as a friend.

From then on, in a sense, practice became one continuous cocktail party. Cocktail parties throw together people with diverse interests and permit them to feel one another out verbally until they find a common bond. On the theory that there's always such a bond if you search for it, I adopted the cocktail-party approach to my patients.

Any Mutual Interests?

First I looked for a common interest—anything. One father had served in the Air Force at the same time I had. Another owned a phonograph-record collection to rival mine. A third pair of parents were having trouble with a dog as unhousebroken as ours. One woman said she and her husband had dealt with the



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Consider Norisodrine in the Aerohalor, Doctor—even for those asthmatics "fast" to other bronchodilators. The simple inhalation technique will be appreciated. Abbott

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contractor who was building my home. And so on.

I quickly learned that such mutual exchanges create a strong camaraderie between doctor and patient. And as my practice began to build up again, I learned something more: Unless you're an ogre, you can find something genuinely likable in every patient you see.

A woman may style her hair attractively. You may like the sports car a patient owns—and wish *you* could afford one. Even Junior may impress you with his cleverness when he deftly picks your pocket.

No Negative Remarks

So I began telling people what I liked about them, their families, or their possessions. If there was anything I didn't like, I kept quiet about it unless professional duty required a comment. (But I carefully refrained from insincere expressions of approval. People can smell insincerity a mile off.)

In addition, I jotted down little personal notes on each person's record. But these reminders became increasingly unnecessary. A face or a name would recall the old conversation.

During house calls, patients often offered me coffee or something to eat. At first I'd feared that accepting such offers would make me seem unprofessional. Now I began to take the coffee even when I didn't want any. After a few sips, it was easy to say apologetically: "Sorry, but I've got to run."

Coffee as a Symbol

The coffee isn't important in itself; it's a symbolic bond between doctor and patient. I know now that when I used to refuse it, I seemed as churlish as the medieval man who refused to break bread with his hosts.

Soon, I even began serving coffee in the waiting room. Parents enjoyed this, especially on cold days; and they seemed less impatient when I ran behind schedule. Before long, they were bringing in cookies to go with the coffee. I believe that this simple idea did more for my reputation than any therapeutic triumph could have done.

My practice mushroomed. New patients came, and old patients returned. And while my practice was growing, I had two experiences that really showed I was on the right track. The first

dramatic results:
acute asthma...
left ventricular failure

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Disposable Rectal Unit

Rectally administered Clysmathane (Solution of Theophylline Monoethanolamine, Fleet) is quickly absorbed by the inferior hemorrhoidal veins... delivers adequate blood levels rapidly and minimizes certain side effects associated with oral or parenteral administration.[1-2]

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Available: PRESCRIPTION PACKAGE of six single doses. Each unit contains 0.625 Gm. theophylline monoethanolamine. *Indications:* For relief of symptoms of acute or chronic asthma and left ventricular failure... as directed.

References: 1. Ridolfo, A. S. and Kohlstaedt, K. G.: "A simplified method for rectal administration of theophylline," *to be published.* 2. Hoobler, S., Personal Communications.

Literature on request

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experience happened very soon after I'd dropped my stiff facade. Let me tell you about it:

Every doctor knows that medical practice involves playing the odds, that most diagnoses are educated guesses, and that the physician often guesses wrong. I'd been warned that a few bad breaks during my first year or so could ruin me. So I was genuinely worried when, one day, I suffered what could have been a major setback.

An Unexpected Result

I had reassured the parents of a large premature baby that the infant was doing well and that he'd soon weigh enough to go home. But on the fourth day, the baby suddenly died. Autopsy revealed a spontaneous subarachnoid hemorrhage.

During the next few weeks, I wondered what effect this bad break would have on my reputation. I could imagine the gossip about how I had "reassured the parents and let the baby die."

Then, one day, a patient brought up the episode. "Terrible about Mrs. X's baby," she said.

"Yes." I waited tensely.

"But she's very grateful to you, Doctor," the woman added. "She's glad you were looking after the baby when it happened. You're such a good friend that she's certain you did all you could."

So that's how I learned that friendly patients don't complain or advertise when things go sour. Because they consider you an interested friend, they accept your medical judgment.

Because they have faith in your judgment, you can obviously practice better medicine. For example, you don't have to rush in with antibiotics when they're not indicated.

Then, too, nobody wants to sue a friend. My colleague who contends that all patients are

in vaginitis

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destroys all **3** *principal pathogens*

Whether vaginitis is caused by Trichomonas, Monilia or Hemophilus vaginalis—alone or combined—TRICOFURON IMPROVED swiftly relieves symptoms and malodor, and achieves a truly high percentage of cultural cures, frequently in 1 menstrual cycle. TRICOFURON IMPROVED provides: a *new* specific moniliacide MICOFUR® brand of nifuroxime, the *established* specific trichomonacide FUROXONE® brand of furazolidone and the *combined* actions of both against Hemophilus vaginalis.

1. *Office* insufflation once weekly of the Powder (MICOFUR [*anti*-5-nitro-2-furaldoxime] 0.5% and FUROXONE 0.1% in an acidic water-soluble powder base). **2.** Continued *home* use twice daily, with the Suppositories (MICOFUR 0.375% and FUROXONE 0.25% in a water-miscible base).

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NITROFURANS—a *new* class of antimicrobials—neither antibiotics nor sulfonamides.

EATON LABORATORIES, NORWICH, NEW YORK

"potential bastards" faces the constant bugaboo of lawsuits. He was recently sued by a patient who'd tripped over his office scale.

I've had people trip in my office. Even worse, a baby once fell from the examining table. But nobody has ever threatened suit.

The Value of Friendship

And here's my second experience—the best example I know of what true friendliness between a doctor and his patients can mean to the doctor himself:

Before I'd been in practice two years, I contracted polio and was sent to a hospital hundreds of miles away. When I returned home thirteen months later, my patients organized a homecoming celebration. Within a few weeks, they then raised $10,000 to help in my rehabilitation. "Everyone pitched in to help a good friend," one patient told me.

What had I done to deserve such a magnificent tribute? Nothing much. I'd just been interested in my patients and enjoyed them for what they were. Which may be a good tip for you. END

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tablets • alka capsules

potent • nonhormonal • anti-inflammatory agent

BUTAZOLIDIN tablets or the Alka capsules are **equally effective but individually adaptable in a wide range of arthritic disorders.**

Recent clinical reports continue to justify the selection of Butazolidin for rapid relief of pain, increased mobility, and early resolution of inflammation.

Gouty Arthritis: "...95 per cent of patients experienced a satisfactory response..."[1]

Rheumatoid Arthritis: In "A total of 215 cases...over half, 50.7 per cent showed at least major improvement, with 21.8 per cent showing minor improvement...."[2] **Osteoarthritis:** 301 cases showed "...a total of 44.5 per cent with complete remission or major improvement. Of the remainder, 28.2 per cent showed minor improvement...."[3] **Spondylitis:** All patients "...experienced initial major improvement that was maintained throughout the period of medication."[3] **Painful Shoulder Syndrome:** Response of 70 patients with various forms showed "...8.6 per cent complete remissions, 47.1 per cent major improvement, 20.0 per cent minor improvement...."[3]

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Availability BUTAZOLIDIN® (phenylbutazone geigy): Red coated tablets of 100 mg. BUTAZOLIDIN® Alka: Capsules containing BUTAZOLIDIN® (phenylbutazone geigy), 100 mg.; dried aluminum hydroxide gel, 100 mg.; magnesium trisilicate 150 mg.; homatropine methylbromide, 1.25 mg.

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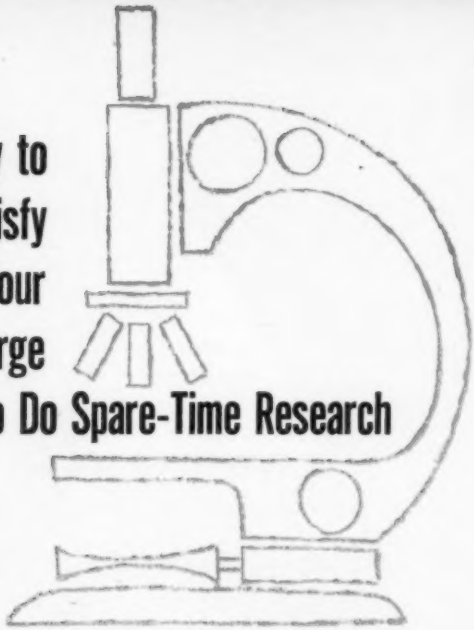
How to Satisfy Your Urge to Do Spare-Time Research



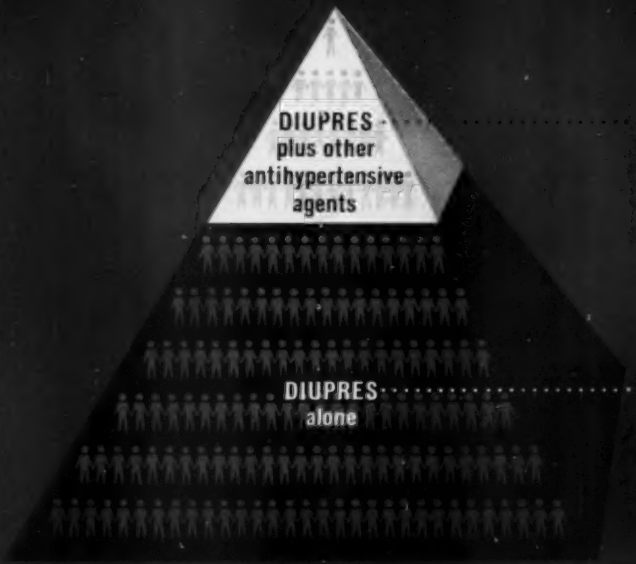
It's exciting, rewarding work. But the obstacles are formidable for any physician in private practice. Listen to what these doctors have to say

By John R. Lindsey

I used to assume that doctors in private practice just don't have time to get deeply involved in the complex world of medical research. But I've recently been talking with practitioners who do research part-time, and they've changed my mind.

What I've learned is that many M.D.s would *make* the time for lab work if they thought it would get them anywhere. But it's apparently mighty hard for the practicing doctor to gain acceptance for his spare-time research project.

"The M.D. has been pretty well pushed out of the main current of medical research," one such man told me. Commented



DIUPRES PROVIDES "BROAD-BASE" ANTIHYPERTENSIVE THERAPY

... is effective by itself in a majority of patients with mild or moderate hypertension, and even in many with severe hypertension

MORE PHYSICIANS *in private practice would find time for spare-time research if they had more opportunity, says Dr. James T. Clark, a general practitioner who's working on a test for diagnosing cancer. He adds: "I'd like to see laboratory centers established throughout the country where doctors could take their ideas and try them out."*

another: "The universities and medical schools have no time for the practicing doctor who wants to do research. As a result, we private physicians have lost confidence in our own competence to do it."

Are you contemplating a little project of your own? If so, you'll be interested in what I've learned from conversations with a couple of your research-minded colleagues.

Take Dr. James T. Clark, for instance. He's a New Rochelle, N. Y., general practitioner who has been working on a test for diagnosing cancer.

"It might be more accurate to say I have an *idea* for a diagnostic test," he told me over a cup of coffee the other morning. "It could be a good idea, but I don't know yet."

He handed me a sheaf of papers covered with neat diagrams and notations of chemical formulas. "This is only the beginning," he explained. "Trouble is, I have no place to work on my experiment. And I suspect that most men in private practice have the same problem. We can usually find time for original, creative research. But where can we do it?"

Dr. Clark, a round, jovial man in his fifties, leaned forward in his chair. "Unless the doctor is affiliated with a university or

TO GAIN MORE TIME *for cancer research, Dr. Bernard Gottfried, a surgeon who directs clinical research in an independent laboratory, gave up 30 per cent of a busy practice. His advice to doctors who feel frustrated because they haven't much chance to work on their own ideas: "Demand more research and teaching-for-research centers."*

large teaching hospital, he's pretty well shut out," he went on. "You can't just drop into a lab and get to work. There's no room; the staff's busy with its own procedures. And the universities don't want you. They want full-time researchers with Ph.D.s in physics and biochemistry."

"But a lot of doctors in private practice do seem to be doing research and writing about it for the specialty journals," I commented.

"Yes, that's true," replied Dr. Clark. "But those men are mostly writing about their observations of patients. I'd call that sort of thing clinical observation, not medical research.

"Most medical research in depth is done in universities, Government centers, pharmaceutical company laboratories, and so on. And none of those institutions has any room for a doctor who wants to work along on his own time at his own pace."

He chuckled softly, then said: "You know, I've been cold-shouldered by so many medical schools and laboratories that I'm now doing my research by mail. Let me tell you about it:

"After about five years of preliminary study, I devised my test for cancer diagnosis in a small hospital lab in St. Albans, Vt. It's a pretty simple test. You mix an alkaloid and a plant substance

with fresh serum from a patient suspected of having cancer. You mix them in a test tube and then you let the mixture stand over night.

"If cancer is indicated, there's a noticeable precipitation—let's say cloudiness. If there's no cancer, the solution remains clear. At least, that's the general idea.

"I was able to do enough tests with fresh serum to interest the cancer people at the Roswell Park Memorial Institute in Buffalo. They undertook an evaluation and reported that the test showed about 75 per cent positive results on patients with proved cancer. They said this wasn't good enough to warrant its use as a diagnostic test. But I found the report encouraging enough to want to go further.

Another Step Forward

"So I asked the National Cancer Institute for the names of medical schools that are particularly interested in cancer diagnosis. Then I wrote to the schools. One of them—the University of Kansas Medical Center—accepted my test for further evaluation last year. That's when the correspondence really started."

Dr. Clark handed me some of the letters from the university's researchers. A line caught my eye: "Can the chicory stems be used green, or must they be dried before using?"

"Chicory stems?" I echoed.

He Pays for Supplies

"It's a matter of economic necessity," Dr. Clark explained. "The university will do the evaluation, but I have to pay for the materials used. Some of the chemical substances I'd been using cost $320 a gram. So I've been trying to use fresh chicory instead, since it has the same elements as the commercial chemicals. It remains to be seen how it works out."

In the meantime, the New Rochelle G.P. isn't happy about the situation. "This long-distance correspondence is far from satisfactory," he told me. "Often the researchers out there ask questions that I can't answer without having access to a laboratory."

Then he said: "I'd like to see laboratory centers established throughout the country where doctors could take their ideas and try them out."

"Are there no such places now?" I asked. *More*▶

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He shook his head. "As far as I know, there's only one laboratory that's especially organized so that a doctor can go in and work out any problem he wants to: the Waldemar Medical Research Foundation in Port Washington, N. Y. If there were more labs like it, you'd find a lot more doctors doing spare-time research."

Facts About Waldemar

When I left Dr. Clark, I did some research of my own. Here's what I found out about the Waldemar Foundation:

It was founded in 1947 as an independent research group by Dr. (Ph.D.) Norman Molomut, an immunologist and physiologist then on the faculty of Columbia University College of Physicians and Surgeons. Dr. Molomut now directs Waldemar on a full-time basis. Its nonprofit research in cancer and allied diseases and its educational activities for students, science teachers, and physicians are financed by voluntary contributions and grants from private foundations and agencies like the American Cancer Society, as well as from

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1. Roden, J.S., and Haugen, H.M.: Missouri Med. *55*:128 (Feb.) 1958.

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Government agencies like the National Science Foundation and the National Institutes of Health.

As Dr. Clark had said, the Waldemar Foundation does open its facilities to private physicians. But it isn't the only laboratory that does so. And it doesn't encourage the research-minded doctor to sit right down and go to work on whatever he feels like.

To find out just what the private practitioner's up against, I next called on Dr. Bernard Gottfried, a busy Long Island surgeon who is also director of clinical research at the foundation—and who manages to find time to do laboratory research in cancer on a regularly scheduled part-time basis.

The Director's View

"I'd like you to tell me something about the Waldemar Foundation," I said. "But first I have a question: Is it your impression that the doctor who wants to do part-time lab research is in for some frustrating experiences?"

Dr. Gottfried thought for a moment. Then he spoke very deliberately:

"The day when a doctor of medicine could make an isolated observation or a single experiment completely on his own is at an end. The problem of the individual physician who wants to do basic research is extremely complex. It's more than just a matter of finding time.

You Can't Solo

"It's a matter of finding the facilities where he can work. Perhaps even more important, it's a matter of finding the trained personnel—outside of a university—with whom he can work. Basic research overlaps so many different disciplines that it has to be a team effort."

Then he said, seeming to weigh each word: "Almost all M.D.s outside of the full-time men in university centers have been eliminated from the mainstream of basic research."

"Well, they can go to your own Waldemar Foundation, can't they?" I asked.

"Yes. Waldemar is one of the few places where a doctor can come in and do something original. There are probably only half a dozen such centers in the country."

Then I asked Dr. Gottfried to tell me how a physician with an

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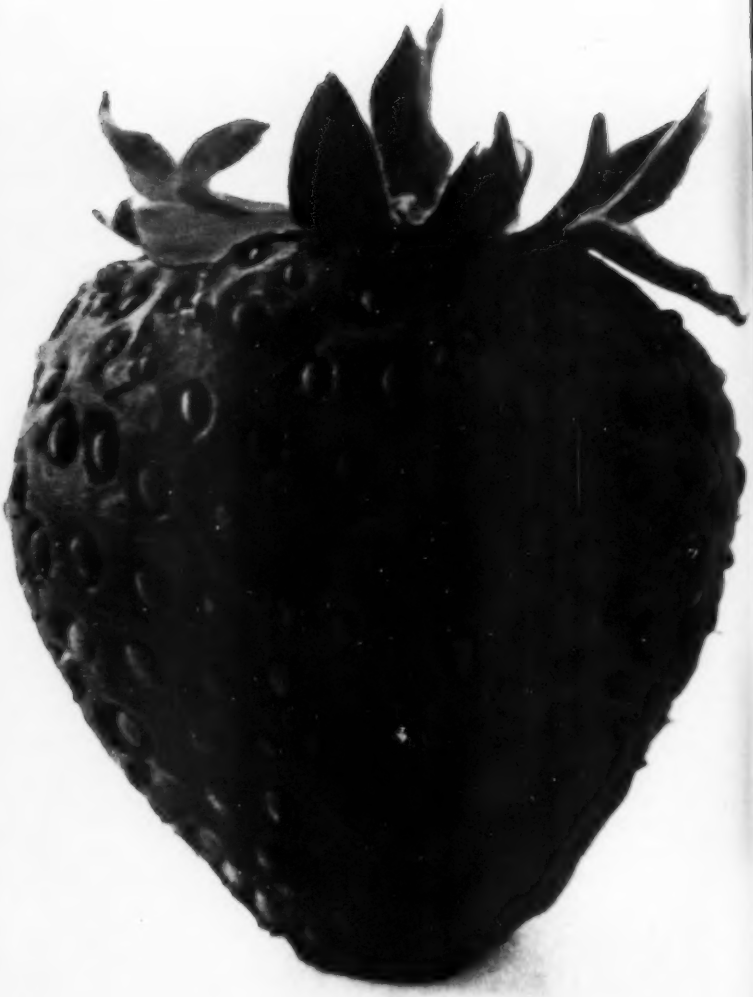

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idea like Dr. Clark's is received at the Waldemar laboratory.

'Open House'

"He's welcome," said the doctor. "We have open house at the laboratory, within the propriety of time. All we ask is that the physician sit down and talk over his idea with us. If we feel the idea has particular merit, we'll go ahead and try to work it out with him."

And if the doctor wants to work on it himself?

"Well, that's something else," said Dr. Gottfried. "It's not a simple question of a single idea, and then sitting down to work with a Bunsen burner. For example, take the thing I'm interested in: tumors and cancer growth. There are a great many disciplines involved. Not just biochemistry and physics and biophysics, but immunology, pathology, cytology, and oncology, which is my special field. We have specialists in all these fields. We also have men who care for the research animals. These days, you just can't work alone.

"Nevertheless we do feel that the man who comes to us with an

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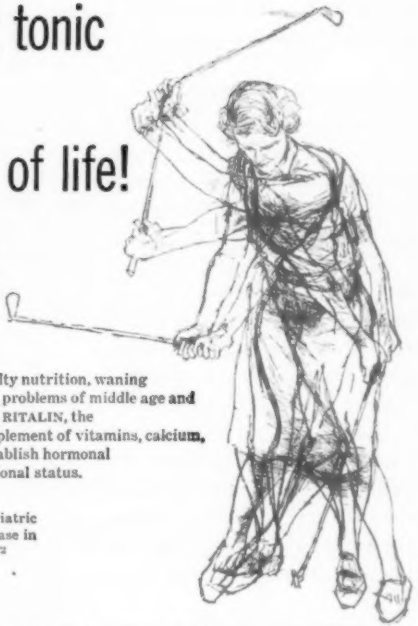

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References:
1. Natenshon, A. L.: J. Am. Geriatrics Soc. 6:534 (July) 1958.
2. Bachrach, S.: To be published.
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C I B A

idea should be given an opportunity to integrate his research skills with those of our staff."

Scheduling's a Problem

"I'm convinced," I said. "But tell me how *you* do it. For one thing, how do you manage to fit your basic research work into your schedule?"

"It isn't easy," Dr. Gottfried answered. "I have a busy practice—surgery and staff meetings at several hospitals, plus appointments with patients in my office. When I finally decided to go in for some serious laboratory research—after about two years of preliminary study and consultation with the staff at the laboratory—I had to rearrange my schedule drastically. Here's what I did:

"I resigned from one hospital staff. This gave me two mornings a week plus one full day, my day off, to work in the laboratory. By keeping to a strict schedule of office hours by appointment only, I've also been able to spend an extra two hours or so a day in the lab. It keeps me hopping. And it's possible only because the lab's within a few miles of my office."

"Just how much of your practice have you given up in order to do part-time research?" I asked.

"About 30 per cent. I think anything less than that would be a dissipation of time."

He was interrupted by a phone call. It was the laboratory, reporting that the mice Dr. Gottfried has been using in his research were now ready for the next stage in an important skin-grafting procedure.

Mice Can't Wait

"See what I mean?" the doctor said, when he'd hung up. "A research timetable is as rigidly demanding as any schedule in surgery. When the mice have been prepared, the skin grafting can't wait. That's why I have to clear my practice schedule to make time for my research schedule. I can't just do it in off-moments."

"You've certainly pointed up the difficulties in the path of the practicing M.D. who wishes he could do part-time research," I commented. In the face of all those obstacles, why have you been willing to give up almost a third of your practice to do laboratory work?"

Dr. Gottfried answered with-

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out hesitation: "Because I believe that future advances in the surgical field and in cancer treatment must await the results of basic research. As a doctor of medicine, I want to help direct and channel such research. I feel that it's my responsibility. And make no mistake about it: I'm convinced that the same thing is true in other areas of medicine and that all practicing physicians probably feel the same responsibility.

"I believe that the entire medical research set-up in this country requires radical overhauling. I believe it's the fault of the medical profession that opportunities for the M.D. in research are so limited. I believe that the profession is guilty of yielding its proper place in research to other disciplines. I believe that our medical schools have helped erect unnecessary barriers against the practicing physician doing basic research."

"Do you have any advice for doctors who feel frustrated because they get so little chance to work on their own pet projects?" I asked, as I prepared to leave.

The doctor smiled. "I can only suggest that they demand more research and teaching-for-research centers like our Waldemar Foundation," he replied. "Let them point out that although every practitioner may not want to do research himself, every practitioner does have a stake in it. It seems to me that all American doctors should insist on having a greater opportunity to bring their practice-connected observations into the over-all research picture." END

Nothing dentured, nothing gained

A patient came in for her check-up two months after breast surgery. She startled me by asking if it would be O.K. for her to start wearing her dentures again. Naturally, I asked her why she hadn't been wearing them.

"Well," she said, "just before the operation, the nurse told me to remove my teeth. No one has ever told me to put them in again."

—GLORIA M. HOPKINS, R.N.

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Lawsuit Situation:

PART 3

WHAT WOULD YOU DO?

This self-test is based on actual court cases. See whether you'd know what to say to patients in these legally dangerous circumstances

1. A woman whom you've treated with radium for fibrous tissue growths has suffered radium burns. Should you . . .

(a) Admit it was your fault? Or

(b) Say your nurse should have been more careful in handling the radium? Or

(c) Tell the patient not to worry because you carry $100,000 worth of insurance? Or

(d) Tell her that you'll start a course of treatment to minimize the effect of the burns?

Commentary: There have been many court cases in which the doctor chose one of the first three ways out; and in each case he was sued because of what he had said to the patient. Too often, a competent physician will invite a lawsuit by unnecessarily assuming blame or by mentioning his insurance coverage. Correct answer in this case: (d).

2. Following a hysterectomy, you discover that all sponges and instruments are accounted for,

---

THIS QUIZ *is based on material prepared for* MEDICAL ECONOMICS *by the late Louis J. Regan,* M.D., LL.B., *authority on malpractice and author of "Doctor and Patient and the Law" (C. V. Mosby Company, St. Louis).*

but that a curved surgical needle is missing. Should you . . .

(a) Arrange to have the patient X-rayed? Or

(b) Say nothing about it, on grounds that you'd only be exposing yourself to litigation?

Commentary: In the actual case, the doctor said nothing and was sued for "deliberate concealment." What's more, he lost the case. He'd turned an honest mistake into fraud. In such a situation, not even the statute of limitations applies. Correct answer in this case: (a).

3. X-ray films you've made of a patient's gastrointestinal tract reveal the presence of a safety pin. When you show the films to the patient, she angrily accuses another doctor of fraud. Her story: Six months ago, Dr. X examined her, found a safety pin in her stomach, operated, and later told her he had removed it. You operate and remove the pin. Now should you . . .

(a) Agree with your patient that Dr. X ought to be prosecuted? Or

(b) Advise her to see a lawyer? Or

(c) Call Dr. X yourself and tell him of the situation?

Commentary: The doctor in this case chose (a); and he found himself accused—along with Dr. X—of fraud. Fortunately, a comparison of X-rays taken by the two physicians six months apart showed distinct differences in the safety pins in question. So the charges were dismissed—and the patient, a confirmed pin-swallower, was later committed to a mental institution. But it's always best to credit your professional colleagues with acting properly until they are proved in the wrong. Correct answer in this case: (c).

4. You get a letter from a patient that reads like this: "I refuse to pay your bill. Ever since you stuck that needle in my spine, I've had terrible headaches, with palsies up and down the legs." Should you . . .

(a) Immediately write the patient and explain in detail the procedure you followed, in order to convince him that it had nothing whatever to do with the symptoms he describes? Or

(b) Tell him you're turning his letter over to your lawyer? Or

(c) Consult your lawyer first before replying?

Commentary: The doctor who

when fear-anxiety
finds its somatic outlet in
cardiac or g.i. symptoms[1]

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Reference: Rosenblum, L. A.: Clin. Med. 6:72, Jan. 1959.

chose to write the patient a detailed defense of his treatment wound up in court. His written statement that he'd done a dozen similar spinal taps without ill effects was turned against him by the plaintiff's counsel, thus: "The doctor was inexperienced in this procedure, having done only twelve taps in his entire career." Correct answer in this case: (c).

5. You've had a hard time with a patient during her pregnancy, delivery, and puerperium. She and her husband seem displeased with the care you've provided, and both have dropped some strong hints to that effect. What's more, it's now ten months since any payment has been made on your bill. Should you . . .

(a) Turn the bill over to a collection agency? Or

(b) Write your patient a needling letter? Or

(c) Wait until the statutory time limit for filing malpractice claims expires before seeking to force payment?

Commentary: A physician who turned such an account over to a collection agency *before* the statute of limitations on malpractice actions had expired antagonized his patient and her husband. They filed a malpractice cross complaint. Result: The physician not only failed to collect his fee, but wound up with a judgment against himself. If he had waited two more months, he'd have been safe from a retaliatory malpractice suit, under his state's one-year statute of limitations. Correct answer in this case: (c). END

Back in business

My patient, an appliance salesman, had undergone major surgery only two days ago and wasn't allowed out of bed. Yet there he was down the corridor, using the phone.

Apparently he was speaking to his wife. "Please bring my order book when you visit me this afternoon," I heard him say. "I've sold a vacuum cleaner to the man in the next bed."

—L. BINDER

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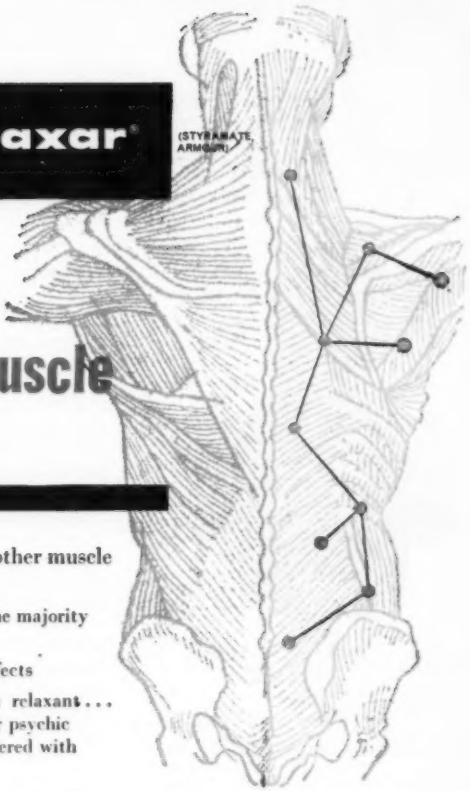

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HOW DELEGATING MORE WORK PAYS OFF

It boosts your expenses, but it boosts your earnings more, this report indicates

By Millard K. Mills

You've read about the fine art of delegating more work. Suppose, now, that you're interested in applying this art—naturally, with modifications to suit your own practice. What's likely to be its dollars-and-cents effect?

Well, obviously, it's going to increase your expenses. After your aide takes on greater responsibility, you'll need to pay her more: a salary of up to $250 a month in a typical small town, perhaps $350 a month in a typical large city, and in some cases even more. (We know one top specialist who recently boosted his aide's salary to $10,000 a year; over a long period, she's proved herself worth it.)

And after your aide reaches peak performance, you'll probably need an additional aide. (Thirty patients a day sometimes justify a second girl; forty patients, a third.) So your overhead is bound to go up—and a good thing, too! Because low overhead

THE AUTHOR *is managing partner of Professional Management Midwest, which has headquarters in Waterloo, Iowa. He is also a member of the Society of Professional Business Consultants. This article is the third of a series updating a classic report on the subject published by this magazine some years ago.*

is too often a symptom of false economy.

So let's assume that you're going to spend more on salaries. How, then, will you get it back —through higher fees, or through higher volume?

Why Penalize Patients?

Higher fees don't seem to be the answer. I have analyzed almost 200 medical practices where the doctor now delegates much more work than before. Typically, his fee schedule hasn't changed; and his patients may pay even *less* for wholly delegated services. (For example, refractions: $15 if done by the doctor, $10 if done by his aide.)

Higher volume, then, appears to be the pay-off. And that's how it's actually working out in nearly all the 200-odd medical practices I've studied. Which should not be too surprising, because the idea makes economic sense:

People these days are attracted by moderate charges. They're attracted by a wide range of services under one roof. They're attracted by efficient management —as long as it's linked with the time-honored personal touch. All

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these things the doctor who delegates can offer them.

The effect on his practice? He sees more patients; he serves them at a higher level; he earns enough to cover his increased overhead—and more besides.

How much more can be suggested by a few case histories. The following cannot be called typical—at least not yet. But they do indicate what happens when doctors make a science of delegating work. (Since income figures are given, identifying details have been disguised.)

Case A: A middle-aged intern-

Amusing . . .
Amazing . . .
Embarrassing . . .

No doubt one of these adjectives describes some incident that has occurred in the course of your training.

Why not share the story with your colleagues?

If it's accepted for publication, you'll receive $25-$40 for it.

Contributions must be unpublished. They cannot be acknowledged or returned. Those not accepted within ninety days may be considered rejected.

Address: Anecdote Editor, MEDICAL ECONOMICS, Oradell, N.J.

"THE MOST EFFECTIVE DRUG EVER USED"[1]*

before the "morning spin" sets in

BONAMINE

brand of meclizine hydrochloride

to prevent **vertigo, nausea, vomiting**

as in **pregnancy**

BONAMINE gives more complete and longer-acting protection—often for 24 hours, with a rare incidence of untoward effects.[2] In contrast to other agents, "percentage of patients obtaining an excellent response... is greater ... Also, there are fewer therapeutic failures"—"at least 90 per cent of the patients improve under this medication"[2]

Also indicated for vertigo, nausea, vomiting in: cerebral arteriosclerosis • other geriatric conditions • pediatric infections • postoperative patients • opiate or other drug therapy • radiation therapy, Menière's syndrome, fenestration procedures, labyrinthitis • motion sickness.

BONAMINE Tablets, scored, tasteless, 25 mg. Boxes of 8, bottles of 100 and 500.

BONAMINE Chewing Tablets, pleasantly mint flavored, 25 mg. Packages of 8.

1. McKenna, C. J.: Am. Pract. & Digest Treat. 6:417, 1955. 2. Moyer, J. H.: M. Clin. North America, March, 1957, p. 405.

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DELICIOUS CHERRY-FLAVORED

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ELIXIR

12.5 mg. per 5 cc.

FOR VERTIGO • NAUSEA • VOMITING

PFIZER LABORATORIES
Division, Chas. Pfizer & Co., Inc.
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Pfizer

ist in a large Minnesota town was laboring along with just a receptionist. When she finally left to get married, he decided to replace her with a higher-caliber girl. He not only found one; he quickly found that she could relieve him of much detail. Soon he

NOT ENOUGH LIGHT?

If you haven't measured the light levels in your office recently, a quick check will probably pay off in more restful, more efficient illumination. Use your own photographic exposure meter if it's calibrated in foot-candles. Otherwise ask your electric utility company to lend you a light meter. It may even send one of its lighting engineers to do the job for you. He'll measure the foot-candles you're now getting on desk tops, examining tables, and every place where light is especially important to you. In other areas—e.g., hallways, lavatories, and such—he'll take measurements on a horizontal plane about thirty inches from the floor.

How many foot-candles should you have in the various areas? The Illuminating Engineering Society recommends the following minimums:

¶ *Ten foot-candles for hallways;*
¶ *Fifteen foot-candles for reception rooms;*
¶ *Twenty foot-candles for stairways;*
¶ *Thirty foot-candles for reading and general work areas;*
¶ *Fifty foot-candles for specialized work areas.*

Many doctors prefer to have forty to fifty foot-candles in *every* room. With that much light—provided the overhead fixtures are properly arranged—supplementary reading lamps aren't really necessary. Brightly lit rooms are usually more cheerful, too.

While fifty foot-candles are usually enough for external medical examinations, you of course need more for other professional procedures. Internal examinations require about 250 foot-candles; office surgery requires about 1,000. END

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triple benefits with
Milprem®

1 ***Fast relief*** of irritability, anxiety, tension, insomnia. Miltown acts in 30 minutes.

2 ***Replacement therapy*** with estrogens helps restore endocrine balance; relieves vasomotor and metabolic disturbances.

3 ***Relaxation*** of skeletal muscle tension; relieves low back pain, tension headache.

Supplied in two potencies for dosage flexibility

Milprem-400

Each tablet contains 400 mg. Miltown and 0.4 mg. conjugated estrogens (equine); bottles of 60.

Milprem-200

Each tablet contains 200 mg. Miltown and 0.4 mg. conjugated estrogens (equine); bottles of 60.

Dosage for either potency: One tablet t.i.d. in 21-day courses with one-week rest periods; should be adjusted to individual requirements.

Literature and samples on request

WALLACE LABORATORIES, *New Brunswick, N. J.*

CMP-8517-29

was successfully handling twenty-five patients a day, instead of the previous nineteen.

The economic effect? Here's what his records showed for the calendar years immediately before and after the change:

	Before	After
Salaries paid	$ 2,400	$ 3,210
Total expenses	7,016	8,621
Total receipts	17,521	22,140
Net profit	10,505	13,519

This illustrates the science at its simplest. Note that the salary increment was only $810. Yet this extra outlay helped boost the doctor's earnings by $3,014 net.

Case B: A family doctor in a small town already delegated almost all his paper work. But his secretary couldn't help him with his growing prenatal case load. So he took on a second aide—an R.N.—and gradually trained her to handle the clinical routine connected with check-ups. In a year, his books showed these approximate results:

	Before	After
Salaries paid	$ 2,820	$ 5,640
Total expenses	9,119	14,028
Total receipts	24,183	36,100
Net profit	15,064	22,072

Thus, by hiring and training a

another
BREON
prescription

NEW FULL RELIEF OF PAIN-FEVER-COUGH

DEMEROL® COMPOUND

(MEPERIDINE HYDROCHLORIDE)

AND FOR RELIEF OF MODERATE TO SEVERE VISCERAL, NEURAL AND SOMATIC PAIN

DEMEROL® APAP

DOSAGE: Adult dose is 1 to 2 tablets orally, repeated if necessary every 3 or 4 hours.

Tablets containing Demerol hydrochloride 50 mg., acetyl-p-aminophenol 300 mg., bottles of 100.

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FOR PATIENTS DESERVING MORE THAN ROUTINE ATTENTION

Triple action of Demerol,® APAP and dihydrocodeinone for:

more than routine *antitussive action*

Cough suppressant action of dihydrocodeinone — at least six times as potent as codeine but essentially nonconstipating — enhanced by the broncho-spasmolytic effects of Demerol.

more than routine *analgesia*

Addition of Demerol to APAP and dihydrocodeinone provides more complete relief of mild to moderate pain. The mild sedation without respiratory depression is widely beneficial.

more than routine *antipyresis*

APAP—Active metabolite of phenacetin — produces more rapid and prolonged fever reduction than aspirin or APC without gastric irritation or hematologic changes.

AVAILABILITY: stratified green, white and pink tablets containing Demerol hydrochloride 25.0 mg., dihydrocodeinone bitartrate 5.0 mg., acetyl-p-aminophenol 150 mg., bottles of 100.

DOSAGE: one or two tablets

clinical aide, this man increased his net earnings by about $7,000. And not long ago, he inadvertently proved just how well he'd trained her:

He himself fell seriously ill, spent a month in Florida recuperating. In his absence, his office did $2,290 gross business—X-rays, laboratory work, and routine follow-ups on cases the doctor had already seen. Not one person complained.

More Time, More Money

Case C: An orthopedic surgeon in a large Iowa town was elected chairman of an important civic committee. He already had two aides in his office: an R.N. and a secretary. Now he hired a third one (another R.N.) so that he could gain more time for outside work.

In this, he clearly succeeded. Only 71 per cent of his billings for the next year stemmed from his own services. The rest stemmed from services rendered by his aides: X-rays, physical therapy, medications, and minor treatment.

This high degree of delegation brought him more than extra time; it brought him financial progress too. Note his figures for the full years before and after the arrival of his third assistant:

	Before	After
Salaries paid	$ 4,225	$ 7,225
Total expenses	18,151	23,006
Total receipts	40,333	48,511
Net profit	22,182	25,505

Case D: Two ENT men in Nebraska had a booming partnership practice. In fact, their three aides couldn't keep up with the paper work; they were too busy providing the necessary clinical assistance. (Some 20 per cent of all billings stemmed from their audiometry, injections, medications, and lab work.)

Discovering that collections had been neglected, the partners hired a fourth aide and made her responsible for telephone follow-ups. In a year, their collection ratio climbed from 84 per cent to 96 per cent. This (plus the natural growth of the practice) made a dramatic difference:

	Before	After
Salaries paid	$ 6,922	$ 9,384
Total expenses	24,416	30,708
Total receipts	69,771	88,218
Net profit	45,355	57,510

From these case histories, it's clear that good management pays. And it pays, remember, because it's what patients want. They don't like waiting; they

don't like sitting there while the doctor putters around; they don't like unnecessary return visits. The doctor who delegates properly can spare them all that.

Delegates *properly*, I said. For as every good doctor instinctively knows, there's a wrong time, a wrong place, and a wrong girl. I can think of no better way to conclude this report than to pass along one successful delegator's description of each:

"The wrong time is when the patient needs your emotional support. If he's really sick, anything *you* can do to comfort him is good medicine—even if it's smoothing a rumpled pillow, or soothing his fears with just plain words.

"The wrong place is outside your office. The techniques of good office management simply aren't appropriate on most house calls and hospital rounds.

"The wrong girl is any girl who doesn't know her own limitations. If you've got one of these, better get rid of her. She'll be controlling policy on delegated work before you know it. And that's neither good management nor good medicine." END

the instant cooling relief of

METI-DERM Aerosol

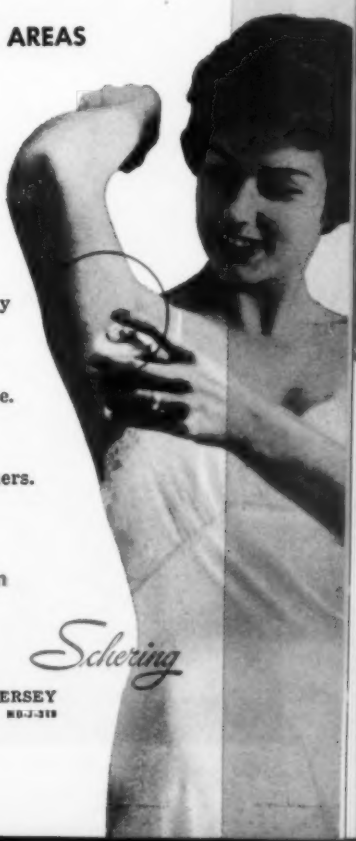
"Meti" steroid topical

and when infection is a factor

METI-DERM with Neomycin Aerosol

especially for

HARD-TO-TREAT
PATIENTS, DERMATOSES, AREAS



formula

METI-DERM Aerosol: Each spray dispenser contains 50 mg. prednisolone. A 3-second spray delivers approximately 0.5 mg., an amount sufficient to cover an area about the size of the hand.

METI-DERM with Neomycin Aerosol: Each spray dispenser contains 50 mg. prednisolone and neomycin sulfate 50 mg. A 3-second spray delivers approximately 0.5 mg. of prednisolone and 0.5 mg. of neomycin sulfate.

packaging

METI-DERM Aerosol and METI-DERM with Neomycin Aerosol, 150 Gm. spray containers.

also available

METI-DERM Cream 0.5%

METI-DERM Ointment 0.5% with Neomycin

METI-DERM,® brand of prednisolone topical.
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MD-J-318

These doctors are sponsoring a new Blue Shield contract that's designed to satisfy the health needs of people over 65. In order to make this possible . . .

THEY'RE TAKING A 60% CUT IN FEES

BY LOIS R. CHEVALIER

Medicine's campaign to provide health coverage for the aged before Congress provides it has swung into high gear in at least one area. Iowa's doctors will soon be doing appendectomies for $60, hysterectomies for $100, hemorrhoidectomies for $40, and other procedures at similarly low rates. They've agreed to accept such drastically reduced fees as payment in full for the care of old people with limited incomes.

Blue Shield contracts providing service coverage on the basis of fees that average 40 per cent of most doctors' customary charges go on sale in Iowa this month. The state's physicians are the first in the country to carry out the mandate of medicine's national leaders: "Do something good for the aged—and do it fast."

Although the Iowa men are first, there are several candidates for the runner-up spot. Doctors in California, Florida, Illinois, Kentucky, Michigan, Nebraska, New Jersey, New York, and West Virginia are working on comparable programs. And they're all doing it in response to a resolution that was passed at the A.M.A. meeting last December.

Some observers thought then that the association's official endorsement of low-fee, low-premium contracts for low-income people over 65 was just an ex-

pression of pious sentiment. But leaders in the state medical societies have given the matter top priority. So it's highly probable that, no matter where you practice, you too will soon have to decide whether you want to participate in some sort of cut-rate Blue Shield plan.

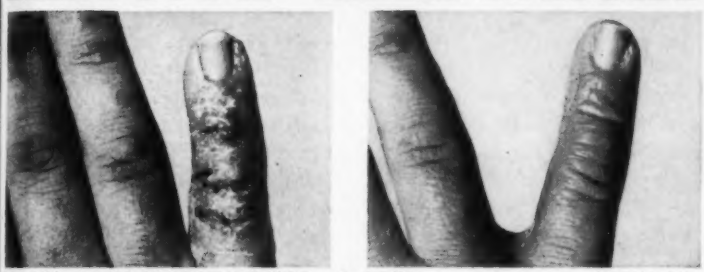
How the Plan Works

The Iowa program grew out of a special February meeting of the state society's delegates. It comes to grips with some of the problems that may be worrying you and your colleagues right now. So, for your information, here's a brief outline of the plan as it's now taking shape:

First of all, who qualifies as an elderly person of "modest resources"?

Iowa doctors set the annual income limit at $2,000 for a single individual, $3,000 for a couple. And they decided that, to be eligible for cut-rate service coverage, the subscriber must have a net worth of no more than ten times the income ceiling. In other words, the new contract will not apply to an elderly person who's worth more than $20,000,

for total management of itching,[1,2] inflamed,[3,4] infected[5,6] skin lesions



Dermatitis repens [with staph and monilia] 7 weeks duration — Cleared in 5 days

new Mycolog ointment

Kenalog, Spectrocin and Mycostatin in Plastibase

antipruritic/anti-inflammatory/antibacterial/antifungal

Mycolog Ointment — containing the new superior topical corticoid Kenalog — reduces inflammation,[3,4] relieves itching,[1,2] and combats or prevents bacterial, monilial and mixed infections.[5-7] It is extremely well tolerated, and assures a rapid, decisive clinical response for most infected dermatoses.

"Thirty-one of 38 patients . . . obtained excellent or good control of dermatological lesions . . . [Mycolog] was highly effective, particularly in the management of mixed infections. Several recalcitrant eruptions which had not responded to previous therapy were remarkably responsive to the daily application of this preparation over periods of 2 to 3 weeks."[8]

For total management of itching, inflamed, infected skin lesions, Mycolog contains triamcinolone acetonide, an outstanding new topical corticoid for prompt, effective relief of itching, burning and inflammation[1-4]—neomycin and gramicidin for powerful antibacterial action[7]—and nystatin for treating or preventing Candida (Monilia) albicans infections.[8,9]

Application: Apply 2 to 3 times daily. Supply: 5 Gm. and 15 Gm. tubes. Each gram supplies 1.0 mg. (0.1 %) triamcinolone acetonide, 2.5 mg. neomycin base, 0.25 mg. gramicidin, and 100,000 units nystatin in PLASTIBASE.

References: 1. Shelmire, J. B., Jr.: Monographs on Therapy 3:164 (Nov.) 1958. • 2. Nix, T. E., Jr., and Derbes, V J.: Monographs on Therapy 3:123 (Nov.) 1958. • 3. Robinson, R. C. V.: Bull. School of Med., U. Maryland 43:54 (July) 1958. • 4. Sternberg, T. H.:Newcomer, V. D., and Reisner, R. M.: Monographs on Therapy 3:115 (Nov.) 1958. • 5. Clark, R. F., and Hallett, J. J.: Monographs on Therapy 3:153 (Nov.) 1958. • 6. Smith, J. G., Jr.; Zawisza, R.J., and Blank, H.: Monographs on Therapy 3:111 (Nov.) 1958. • 7. Monographs on Therapy 3:137 (Nov.) 1958. • 8. Howell, C. M., Jr.: North Carolina M. J. 19:449 (Oct.) 1958. • 9. Bereston, E. S.: South. M. J. 50:547 (April) 1957.

SQUIBB

Squibb Quality — the Priceless Ingredient

nor to an elderly couple worth more than $30,000.

What about the potential subscriber who has little money of his own but whose family is well heeled? Answer: He can have the new coverage if he wants it.

"We decided we'd have to evaluate the old person's resources on a dollars-and-cents basis only," explains Dr. Walter Abbott, president of the Iowa State Medical Society. "If he gets free eggs and milk from his grown son's farm, there's no way we can count it in."

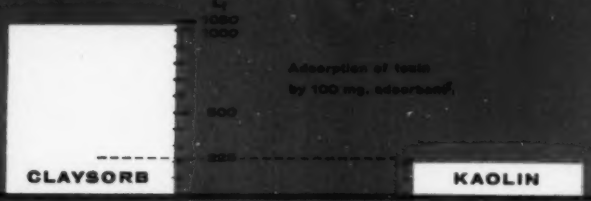
There are some 200,000 Iowa residents who may be eligible for the cut-rate contracts. But it's up to them to *prove* their eligibility. Says a representative of the state's Blue Shield plan:

"If an aged person can prove he meets the criteria we've set up, his membership card will have a special code number on it. His doctor will then know he's one of the low-fee subscribers."

As for the fee schedule, it's based on Iowa's "unit fee index" —the doctors' name for their relative value scale—in line with suggestions from the A.M.A. and national Blue Shield. *More*▶

in diarrhea . . .

adsorptive power



CLAYSORB is 5 times as adsorptive as kaolin

When you prescribe POLYMAGMA or POLYMAGMA Plain to control diarrhea, you are prescribing adsorptive superiority. Both preparations contain Claysorb—a new intestinal adsorbent whose superiority over kaolin has been demonstrated in exhaustive studies.[1,2,3]

For *bacterial* diarrhea, POLYMAGMA is bactericidal to many intestinal pathogens. It is soothing and protective to the irritated mucosa. It aids in the restoration of normal intestinal function. Highly effective, highly palatable.

For *nonbacterial* diarrhea, POLYMAGMA Plain —same formula but without antibiotics.

1. Barr, M., and Arnista, E.S.: J. Am. Pharm. A. (Scient. Ed.) *46*:493 (Aug.) 1957. 2. Barr, M., and Arnista, E.S.: *Ibid.* *46*:486 (Aug.) 1957. 3. Barr, M.: *Ibid.* *46*:490 (Aug.) 1957.

Polymagma®

Dihydrostreptomycin Sulfate, Polymyxin B Sulfate, and Pectin with Claysorb* (Activated Attapulgite, Wyeth) in Alumina Gel

*Trademark

Wyeth Philadelphia 1, Pa.

This advertisement conforms to the Code for Advertising of the Physicians' Council for Information on Child Health.

The index rates procedures in points, not dollars. It already serves as a basis for the state's Blue Shield contracts. The top contract is designed to provide payment of the doctor's usual fees, at $5 per point. But under the new contract for the aged, he'll be paid only $2 per point —a 60 per cent drop. (Because of their higher expense ratios, radiologists and pathologists will take a cut of only 40 per cent.)

As a result, doctors will be accepting payments pretty much like those in the following selected list:

Hospital visit, first day	$ 5
Succeeding visits, next 29 days	2
Hemorrhoidectomy	40
Appendectomy	60
Herniorrhaphy, inguinal, unilateral	60
Mastectomy, simple	60
Hysterectomy, total	100
Thyroidectomy, subtotal	100
Prostatectomy, subtotal	120
Colectomy	160
Arthroplasty, hip	200

With fees like those above, the doctors think their plan can be sold for a premium of less than $3 a month per person. Low as they are, both fees and premiums are a shade higher than the pattern proposed by national Blue Shield at the request of the A.M.A.* And it seems likely that most states will follow Iowa's lead in attempting to make the program more acceptable to local doctors.

As Dr. Bruce Wiley, chairman of the Council of the Michigan State Medical Society, puts it: "There's a problem of salesmanship to our own physicians."

Thus, for example, Dr. George E. Evans, president of the West Virginia State Medical Association, hopes for "a fee schedule and premiums that are 50 per cent below our regular contract." And California's doctors have already voted to accept only a 40 per cent cut.

Significantly, though, the do-something-for-the-aged doctors are meeting less resistance than they'd expected in states where Blue Shield pays cash indemnities only. There's a strong feeling that doctors in such states—Ohio, Indiana, and Kentucky, for example—*will* draw up low-fee service contracts for people over 65.

What if there's a nation-wide

*For a full discussion of the model contract outlined by medicine's top leaders, see "Lower Your Fees for the Aged," MEDICAL ECONOMICS, April 13.

round
and round
and round
she goes
but when she eats, nobody knows.

MYADEC helps correct vitamin-mineral deficiencies in people whose dietary habits are poor. Just one capsule daily supplies therapeutic potencies of nine important vitamins together with significant amounts of eleven essential minerals and trace elements.

MYADEC®

high potency vitamin-mineral formula

Each MYADEC *Capsule contains:*

VITAMINS:

Vitamin B_{12} crystalline	5 mcg.
Vitamin B_2 (riboflavin)	10 mg.
Vitamin B_6 (pyridoxine hydrochloride)	2 mg.
Vitamin B_1 mononitrate	10 mg.
Nicotinamide (niacinamide)	100 mg.
Vitamin C (ascorbic acid)	150 mg.
Vitamin A	(7.5 mg.) 25,000 units
Vitamin D	(25 mcg.) 1,000 units
Vitamin E (d-alpha-tocopheryl acetate concentrate)	5 I.U.

MINERALS (as inorganic salts):

Iodine	0.15 mg.
Manganese	1.0 mg.
Cobalt	0.1 mg.
Potassium	5.0 mg.
Molybdenum	0.2 mg.
Iron	15.0 mg.
Copper	1.0 mg.
Zinc	1.5 mg.
Magnesium	6.0 mg.
Calcium	105.0 mg.
Phosphorus	80.0 mg.

Bottles of 30, 100, 250, and 1,000.

PARKE, DAVIS & COMPANY
DETROIT 32, MICHIGAN

leap onto the bandwagon that Iowa doctors have started rolling? Will it have the hoped-for effect? Will the doctors' action weaken the arguments of those who insist that Government must step in and help the aged?

Many informed doctors fear that some version of the Forand bill is certain to become law, no matter what.* But even if that happens, say medicine's leaders, it will be a matter of public record that America's physicians can and do change their ways to meet society's needs. END

*For a striking expression of this point of view, see "Doctors Can't Beat the Forand Bill" on page 199 of this issue.

GET OFF THE PHONE!

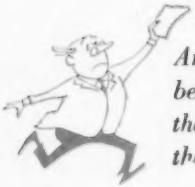
Have you ever been interrupted while doing a little office surgery by an "urgent" phone call from a colleague? It happened to Dr. Clifford L. Graves of San Diego a while ago. The caller was a psychiatrist who had phoned earlier, while Dr. Graves was out, and had declined to leave his number because "he didn't want to be disturbed." So, Dr. Graves reports, "he disturbed *me*"—with a routine report that could easily have been sent by mail.

Telephoning seems so convenient. And it is—to the doctor placing the call. But to the doctor on the receiving end, such a call may be "an invasion of his office, a damper on his work, a break in his mental processes."

Once Clifford Graves got thinking about these things, he checked back on some of his own recent calls to colleagues. Findings? "A surprising number . . . were on matters that could have been handled equally well by mail. I was as bad as my friend the psychiatrist!"

This useful bit of self-analysis may well apply to us all. So, too, may the San Diego doctor's solution: "Now, whenever I can, I throw my business to the post office instead of to the telephone company . . . It may require a little more effort . . . but it gives the [recipient] the freedom to take notice at *his* convenience, rather than at mine." END

How to Collect From an Estate



Are you writing off deceased patients' bills because collecting them seems more trouble than it's worth? It isn't, usually. Here's the way to go about it

By Clifford F. Taylor

Doctors in three eastern states were recently asked what they did about amounts owed them by someone who had died. Most of them said that getting full payment from an estate needed either a lawyer or lots of luck. All of them seemed willing to write off fairly substantial bills rather than "get all tangled up in legal red tape."

"Collecting from any estate is trouble," says a surgeon in White Plains, N. Y. "Generally the family lawyer will call me and offer to settle my $300 bill, say, for $100. I don't want to go to court about it, so I settle."

"If the amount is so large that I can't afford to write it off," says a Doylestown, Pa., G.P., "I turn it over to my lawyer and let him handle it. But I figure a small bill isn't worth the legal bother of trying to collect. I forget it."

And a Hackensack, N. J., internist reports: "I send my bill to the family. Sometimes I get paid, but it usually takes months, even years. Often the bill is simply ignored. I finally write it off."

If you've wondered what to do

V-CILLIN K® offers these three advantages...

1. **dependability.** All patients show therapeutic blood concentrations of penicillin with recommended dosages.
2. **speed.** Therapeutic concentrations appear in the general circulation within five to fifteen minutes after administration.
3. **effectiveness.** Higher blood levels are achieved than with any other oral penicillin given. Infections resolve rapidly.

Dosage: 125 or 250 mg. three times daily. Supplied: Tablets (scored) of 125 and 250 mg. (200,000 and 400,000 units). For full information, please refer to page 708 of your *Physicians' Desk Reference*.

V-Cillin K® (penicillin V potassium, Lilly)

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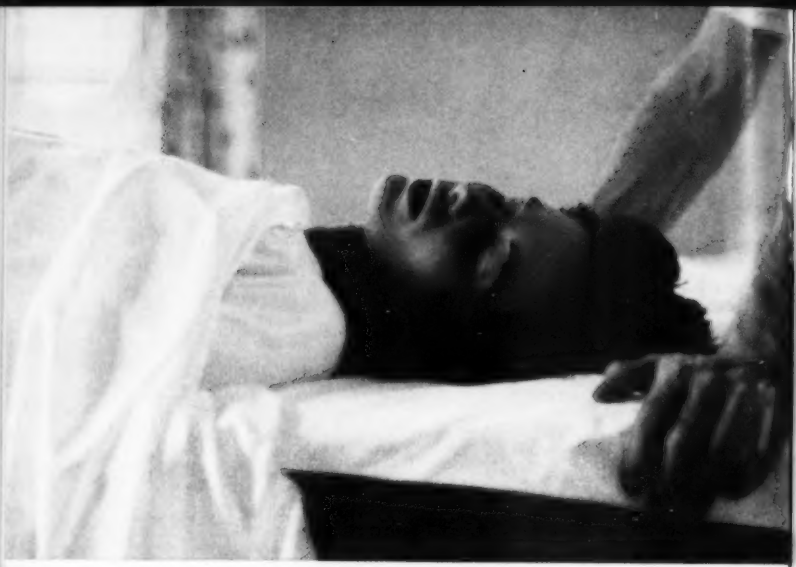
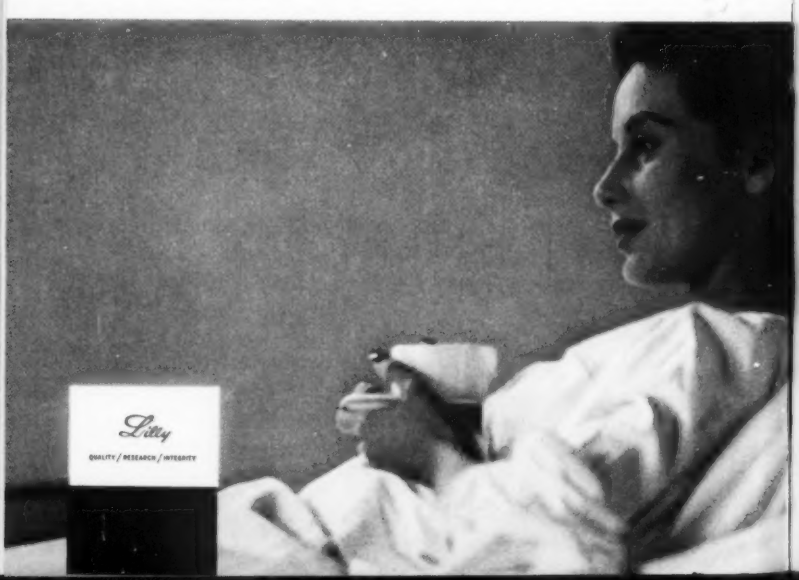


Relief from cramping postpartum pain

"It would appear that Darvon is a safe drug to use in the puerperium . . ."[1]



DARVON® COMPOUND

(dextro propoxyphene and acetylsalicylic acid compound, Lilly)

POTENT · SAFE · WELL TOLERATED

The clinical usefulness of Darvon® (dextro propoxyphene hydrochloride, Lilly), alone and in combination, has been substantiated by more than 100 investigators in the treatment of over 6,300 patients in pain. A consolidation of these reports shows that 5,663 (89.8 percent) experienced "effective analgesia."

439 postpartum patients were included. In 400 (91.1 percent), effective analgesia was obtained; the other 39 (8.9 percent) did not respond.

Darvon Compound combines in a single Pulvule® the analgesic action of Darvon with the antipyretic and anti-inflammatory benefits of A.S.A.® Compound (acetylsalicylic acid and acetophenetidin compound, Lilly). When inflammation is present, Darvon Compound reduces discomfort to a greater extent than does either analgesic given alone.

Usual dosage: 1 or 2 Pulvules three or four times daily.

Also available: Darvon, in 32 and 65-mg. Pulvules.

Usual dosage: 32 mg. (approximately 1/2 grain) every four hours or 65 mg. (1 grain) every six hours.

1. Abrams, A. A.: Personal communication.

ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U.S.A.

920234

about this problem, take a tip from these facts:

Pressing a claim against an estate is usually a simple procedure. You or your aide can often handle it without a lawyer's help. And doing it the right way will usually get action on your bill.

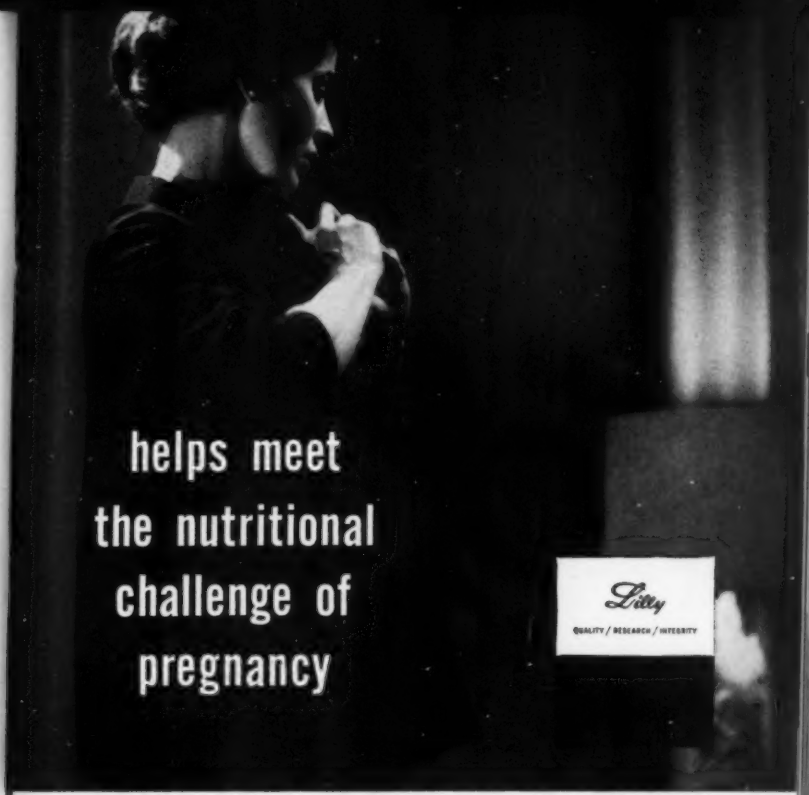
What is the right way? It differs from state to state. But in general, it's merely a matter of submitting your claim to the per-

Time Limits for Filing a Claim

When a person dies, some notification of the death must be published or posted, according to the laws of all states. Creditors must then file their claims within the number of months shown below from the first notification of death.

State	Time Limit In Months	State	Time Limit In Months	State	Time Limit In Months
Ala.	6[2]	Ky.	—[1]	N.D.	3
Alaska	6	La.	—[1]	Ohio	4[3]
Ariz.	4	Me.	6[2]	Okla.	4
Ark.	6	Md.	6	Ore.	6
Calif.	6	Mass.	—[1,2]	Pa.	12[4]
Colo.	6[2]	Mich.	2-4[1]	R.I.	6
Conn.	6-12[1]	Minn.	4[2]	S.C.	5
Del.	9[2]	Miss.	6	S.D.	4
D.C.	6[2]	Mo.	9	Tenn.	9
Fla.	8	Mont.	4	Tex.	12[3]
Ga.	6	Neb.	3-18[1]	Utah	2-4[1]
Hawaii	4	Nev.	3[1]	Vt.	6[1]
Idaho	4	N.H.	6-12[1,3]	Va.	6[3]
Ill.	9[2]	N.J.	6[2]	Wash.	6
Ind.	6	N.M.	6	W.Va.	6-8[1,2]
Iowa	6	N.Y.	—[1]	Wis.	3-12[1]
Kan.	9	N.C.	6-12[1]	Wyo.	6

[1] Limit is fixed by court depending on the size of the estate. [2] Limit is figured from date of court order. [3] Limit is figured from date court recognizes executor or appoints administrator. [4] Limit is figured from date of death.



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when the "parasitic fetus" drains maternal stores

Even *in utero*, baby will have his way. Nature favors his need to build up a store of nutrients for his own biochemical processes—often at the expense of the mother-to-be.

Supplementation of her normal dietary intake with the comprehensive Compren formula will not only help overcome maternal deficiency but will also insure an adequate supply to the "parasitic fetus." Prescribe 1 to 3 Pulvules® daily for better health and fewer complications for both mother and child.

Compren® (prenatal dietary supplements, Lilly) 909000

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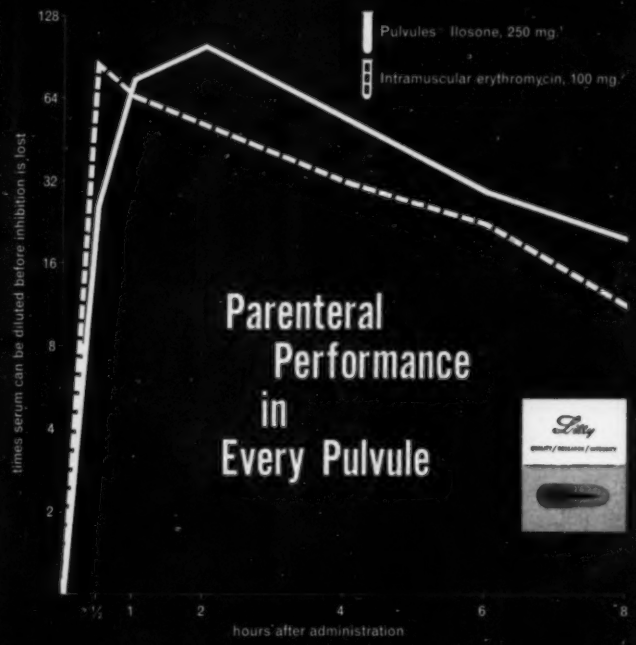
son in charge of the estate. If the deceased left a will, the person in charge is an executor; if no will was left, the person to send the bill to is an appointed administrator. A telephone call to the courthouse of the county where the deceased lived should tell you who it is.

Billing Is Simple

In some states, all that's needed is to send the bill to the executor or administrator. In other states, a special claim form must be filed with the probate court, surrogate, or registrar of wills. The agency or official with whom you're to file it can supply the claim form, and can also give you the exact procedure to be followed in your state.

It may be that filing the claim form is sufficient. Or it may be that you must file the claim form *and* submit either a copy of it or a bill to the estate's executor or administrator. Either way, it's a simple routine and not the embroiled legal process that many physicians think.

"I didn't get around to submitting my claim until about a year after my patient died," a New



ILOSONE™ assures a decisive response in common bacterial infections

Parenteral potency—The graph above shows that Ilosone provides antibacterial serum levels comparable to those obtained with intramuscular therapy.

Parenteral certainty—In more than a thousand determinations, in hundreds of patients studied, Ilosone has never failed to provide significant antibacterial levels in the serum.

The usual dosage for adults and children over fifty pounds is 250 mg. every six hours, but doses of 500 mg. or more may be administered safely every six hours in more severe infections. For optimum effect, administer on an empty stomach. Supplied in Pulvules of 250 mg. (For children under fifty pounds, a 125-mg. Pulvule is also available.)

Ilosone™ (propionyl erythromycin ester, Lilly)

1. Antibiotic Med. & Clin. Therapy, *5*:609, 1958.
2. Data from Antibiotics Annual, p. 269, 1954-1955.

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932303

York City doctor reports. "I was told the estate was settled, and I was out of luck. What do you do in a case like that?"

How Late Is Too Late?

In most cases, there's nothing you can do. Each state has its own time limit for presenting claims on an estate. The table on page 180 gives these time limits. And if you don't file within the period allowed by your state, you have little chance of collecting.

A late claim *may* be allowed at the court's discretion in some states. You might get this leeway if you could prove to the court you had no way of knowing of the patient's death.

Once you've submitted your claim, the same statute of limitations applies on collecting it as on any other bill. But here's a tip from a medicolegal adviser:

"If it looks as if the estate may be tied up indefinitely in litigation or settlement, try to get the executor or administrator to acknowledge your claim in writing. The statute of limitations on collectibility begins with the date of that admission. And each time the admission is made anew, the

SANDRIL® c̄ PYRONIL® adds antihistamine to reserpine therapy

Although the nasal stuffiness commonly caused by reserpine preparations is seldom serious, it may be bothersome enough to induce patients to cease therapy.[1]

Clinical experience[1,2] has revealed that the antihistamine, Pyronil, provides relief for approximately 75 percent of patients who experience this side-effect. Therefore, Sandril c̄ Pyronil offers you better patient control by providing greater freedom from nasal congestion.

Each tablet combines:

Sandril . . . . . 0.25 mg.
Pyronil . . . . . 7.5 mg.

Usual Dosage: 1 tablet b.i.d.

Sandril® (reserpine, Lilly)

Also: Sandril, as tablets of 0.1, 0.25, and 1 mg., and elixir, 0.25 mg. per 5-cc. teaspoonful.

1. Geriatrics, *12*:185, 1957.
2. J. Indiana M.A., *48*:603, 1955.

Pyronil® (pyrrobutamine, Lilly)

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971000

time limit is extended all over again."

Assuming your claim is accurate, itemized, and reasonable, it probably won't be questioned by the executor or administrator. But if he does question it, should you stand up for your rights? Or should you, like the surgeon quoted earlier, be willing to settle for less rather than go to court?

That depends on the size of the estate and the financial status of the heirs. If there's any question of hardship, you'll undoubtedly prefer to settle for a percentage of the bill—or write it off completely. But when the estate is substantial, and the executor or the heirs are simply trying to protect "their" money, you're usually justified in having your lawyer take your claim to court.

One M.D. puts it this way:

"Never hesitate to sue an estate for the amount you're rightfully owed. It's entirely outside the realm of goodwill or community relations. You're not suing the patient. You're battling a lawyer who's trying to save the heirs some money. And you can bet he's not trying to save it on his fee—just on yours." END

Shock treatment

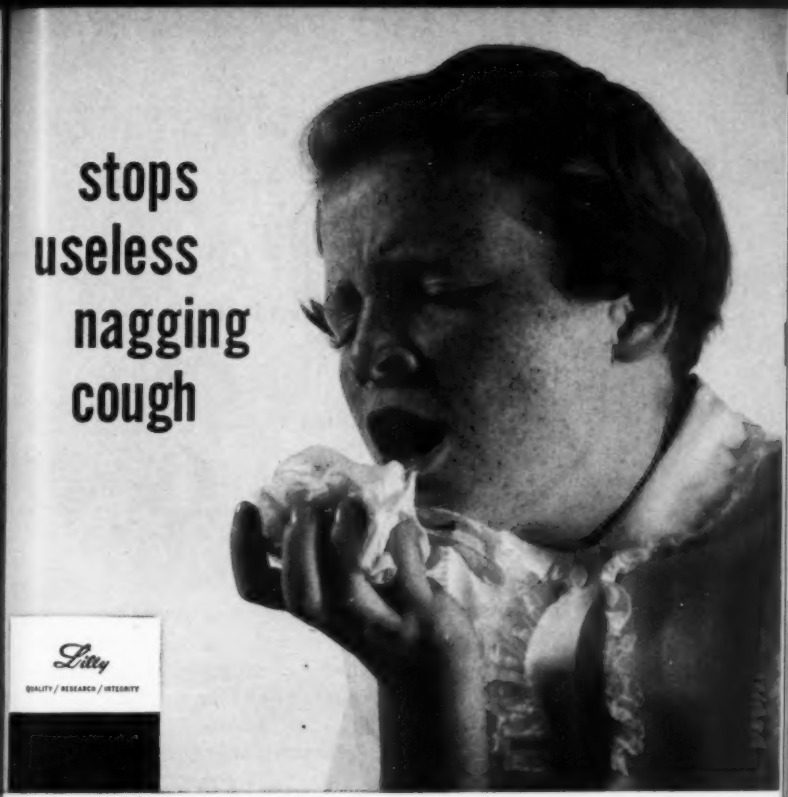
The patient was admitted to the hospital with paraplegia of sudden onset. The attending physician, after giving her a thorough neurological work-up, concluded that the paralysis was hysterical.

That evening he left orders that she be given a large dose of a cathartic. He told the nurse to delay responding when the patient called for the bedpan.

During the night, the call light flashed. Then it flashed again . . . and again . . . and again. Finally the nurse answered it, only to find the patient on the toilet in the bathroom—fifteen feet from the bed.

When notified of the cure, the doctor said, "I'm glad it worked. I figured she was too much of a lady to stay in bed in *that* situation."

—LOUIS S. MOORE, M.D.



°syrup HISTADYL™ E.C.... effective, pleasantly flavored antitussive

Histadyl E.C. is a logical combination to quell uncomplicated, nonproductive, hacking cough:

Action Desired	Active Ingredient (per teaspoonful)	
antitussive	Codeine Phosphate	1/6 gr.
antihistamine	Thenylpyramine Fumarate	1/5 gr.
expectorant	Ammonium Chloride	1 2/3 grs.
bronchodilator	Ephedrine Hydrochloride	1/12 gr.

°Federal record of sale required.

Histadyl™ E.C. (thenylpyramine compound E.C., Lilly)

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Injections Without Tears: Kids Go for This Game

Are crying children a problem around your office? This pediatrician has the answer

By Frank Howard Richardson, M.D.

Toward the end of office hours yesterday, a 4-year-old was announced. I stepped into the waiting room and found him cowering in a corner there instead of trying out the hobby-horse. And I knew from experience what was wrong.

"You think I'm going to give you a shot, don't you?" I asked. The little fellow stopped sniffling and nodded. But his mother informed me that she had brought him in simply for treatment for a common cold. So I felt justified in assuring the lad that I was *not* going to give him a shot.

"Maybe you won't, but your nurse will," he countered. He had evidently heard something along those lines before.

"No," I replied. "Nobody will give you a shot here today, even if you beg for one."

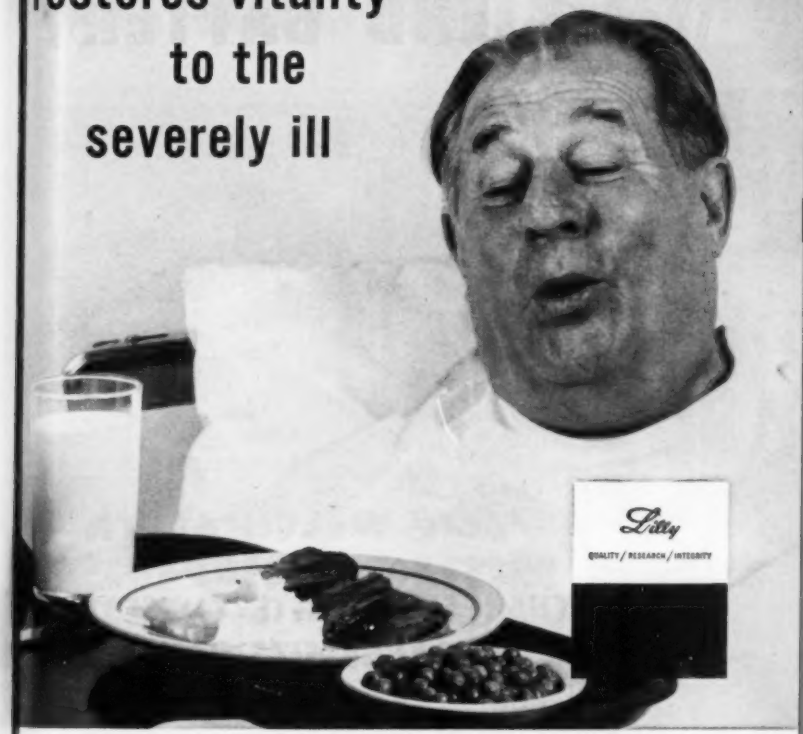
He smiled in spite of his fears, at the idea of his asking for it. And his relief when I repeated my promise would have been amusing had it not been so pathetic. From then on, I had no trouble at all with my examination.

This visit reminded me that "getting a shot" is still what small

---

THE AUTHOR *practices pediatrics in Asheville, N.C. He has written "How to Get Along With Children," published by Tupper and Love, Inc., as well as eleven other books.*

restores vitality to the severely ill



THERACEBRIN® multiple vitamins so potent patients can feel the difference

"The patient who requires therapeutic doses has probably depleted those vitamin stores . . . so that one has not only the problem of maintenance requirement but the restoration of stores."[1] It is generally agreed that five to ten times the minimum daily allowances of vitamins are needed to achieve rapid response in such cases.

The "husky" Theracebrin formula falls well within this range. In fact, it is the *most potent multiple vitamin you can prescribe.* Use Theracebrin as a valuable adjunct to specific therapy—especially following surgery and burns and in infectious hepatitis, malnutrition, and chronic debilitating diseases.

1. Kaye, Robert: Vitamins and Other Nutrition Factors in Clinical Practice, Delaware M.J., 28:51, 1956.

Theracebrin® (pan-vitamins, therapeutic, Lilly)

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- **Always fully charged in office use.** Place handles in charger when not in use and they recharge automatically. Can't overcharge.
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- **Handles are small and lightweight,** even smaller than WA medium (No. 705) handle.
- **Compact, attractive charger** takes only 7½" x 4" space on desk, or installs on wall bracket. Plugs into 110 v. AC outlet.
- **Handles have Permafit collar,** accept any WA instrument head.

No. 712, 2 rechargeable handles with desk type charger (less instrument heads) $60.00

WELCH ALLYN

LIGHTS THE WAY

fry fear most. Reassure them that they're *not* getting a shot today, and you'll reduce the noise level almost as much as if you'd just soundproofed your office.

But what if a hypodermic or intramuscular injection is indicated? Here, too, it's a simple matter to hold down the decibel count without holding down the patient. There are surely many good techniques. Mine goes like this:

Two Ways to Shoot 'Em

After making my initial contact in as friendly a way as I would if his father or mother were the patient, I tell the youngster that I'm going to give him a shot. In the same breath, I tell him that I have two ways of giving shots and that he can take his pick. One is *his* way, watching everything I do. And that will probably hurt. The other way is *my* way; and I say I don't believe this will hurt at all, if he does exactly what I tell him to do.

Since I'm telling the truth when I say this, my words usually carry conviction. Unless he's unusually backward, he generally chooses to take it my way—though, of course, without undue enthusiasm.

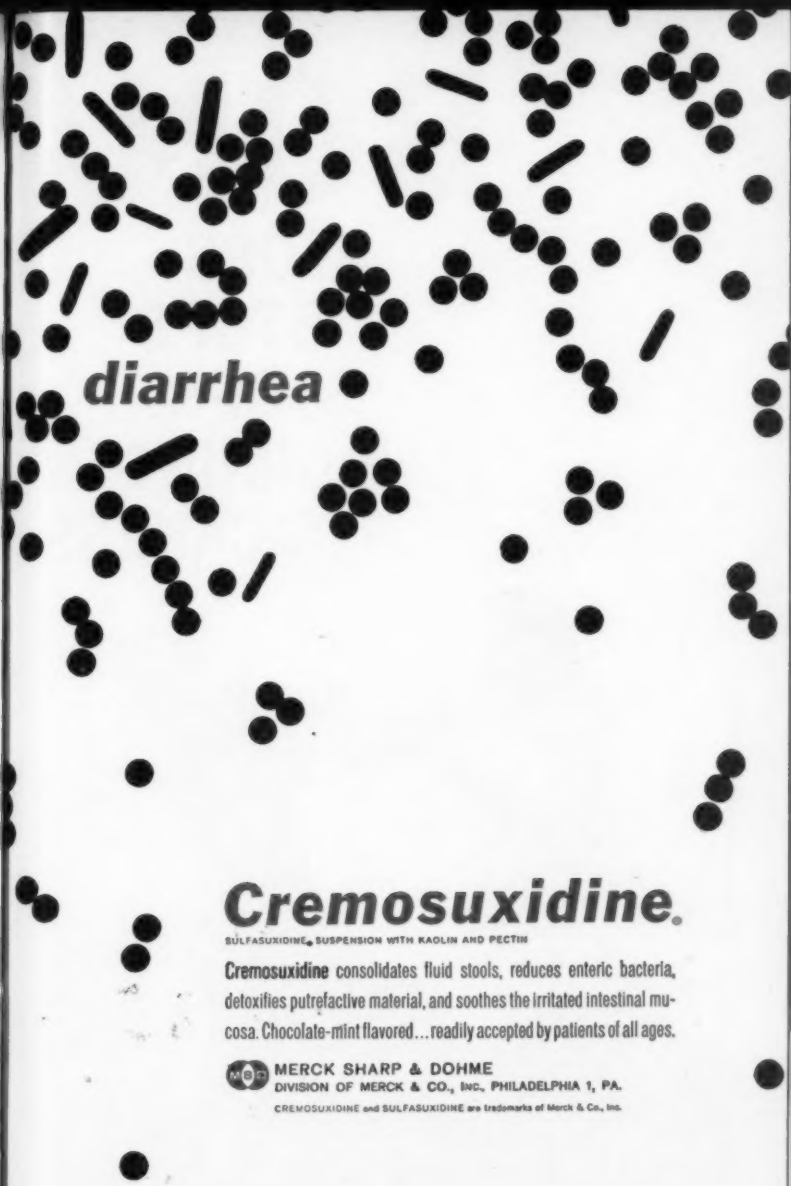
I then give him his choice of one of several toys—none of them worth more than 5 cents—which his mother holds for him. If he can tell when I give him his shot, he can have the toy for keeps. But I point out that I don't believe he'll win it. This puts him on his mettle.

What Sharp Fingers!

Next, I tell him that I'm going to poke him with my forefinger ten times and that, without peeking, he is to say which one is the shot. If he guesses wrong, then it certainly can't have hurt him. If he guesses right, the toy belongs to him.

I poke him and count "one," then "two." Next, I touch him lightly with the needle point as I count "three." Finally, at "six" or "seven," I slip the needle in. At "eight" I hesitate uncertainly, and say, "Of course, if you're sure you don't want the shot, I won't give it to you."

He heaves a sigh of relief at the thought of a reprieve, then looks up and sees his mother laughing. When he realizes that he has already had the shot without knowing it, his relief is truly touching. He tries his best to guess which poke was the shot,



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Cremosuxidine consolidates fluid stools, reduces enteric bacteria, detoxifies putrefactive material, and soothes the irritated intestinal mucosa. Chocolate-mint flavored... readily accepted by patients of all ages.

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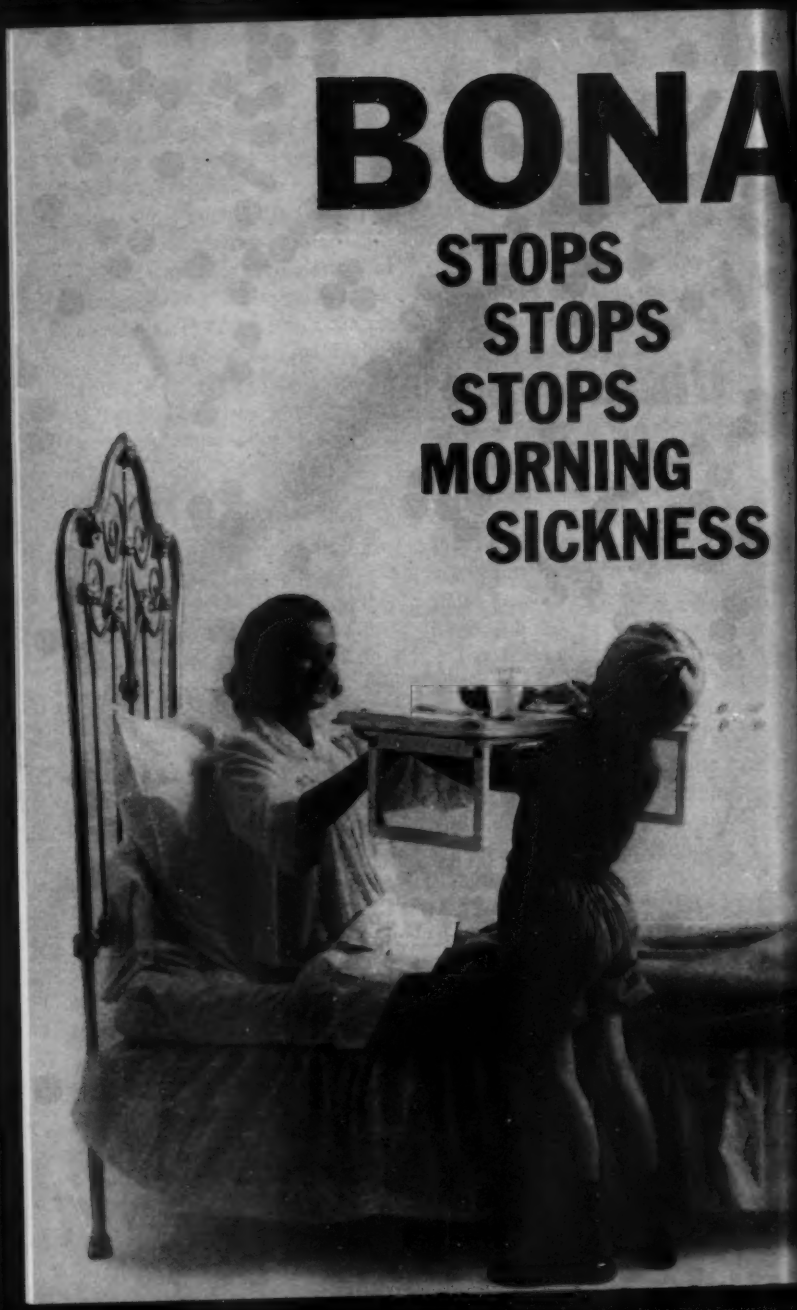
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STOPS
STOPS
MORNING
SICKNESS

ADOXIN®

(tablets and drops)

BONADOXIN Tablets relieve nausea and vomiting of pregnancy in 9 out of 10,[1-7] often within a few hours.

Moreover, a controlled study of 620 cases reported that with BONADOXIN "toxicity and intolerance [are] zero."[1] BONADOXIN is rarely soporific. It is free from the risks associated with overpotent tranquilizer-antinauseants.

NOTE: BONADOXIN has also been shown highly effective in relieving nausea and vomiting associated with: anesthesia, radiation sickness, Meniere's syndrome, labyrinthitis, cerebral arteriosclerosis, and motion sickness.

Each tiny pink-and-blue BONADOXIN tablet contains:

Meclizine HCl (25 mg.) . . . for antivertiginous, antinauseant effects.

Pyridoxine HCl (50 mg.) . . . for specific metabolic replacement.

DOSAGE: usually one tablet at bedtime. Severe cases may require another dose on arising.

SUPPLIED: tiny pink-and-blue tablets, bottles of 25 and 100. Fruit-flavored, clear green syrup in 30 cc. dropper bottles.

Infant colic? BONADOXIN DROPS are antispasmodic...stop colic in 84%,[8-10] without the risk of belladonna and barbiturates.

Each cc. contains:
Meclizine dihydrochloride .. 8.33 mg.
Pyridoxine hydrochloride ...16.67 mg.

Dosage:

under 6 months	0.5 cc.	2 or 3 times daily, on the tongue, in fruit juice or water
6 months to 2 years	1.5 to 2 cc.	
2 to 6 years . .	3 cc.	
adults and children over 6	1 tsp. (5 cc.)	

References: 1. Goldsmith, J. W.: Minnesota Med. 40:99 (Feb.) 1957. 2. Groskloss, H. H., et al.: Clin. Med. 2:885 (Sept.) 1955. 3. Weinberg, A., and Werner, W. E. F.: Am. Pract. & Digest Treat. 6:580 (April) 1955. 4. Crawley, C. R.: West. J. Surg. 8:463 (Aug.) 1956. 5. Tartikoff, G.: Clin. Med. 3:223 (March) 1955. 6. Dunn, R. D., and Fox, L. P.: Clinical exhibit. 7. Codling, J. W., and Lowden, R. J.: Northwest Med. 57:331 (March) 1958. 8. Dougan, H. T.: Personal communication. 9. Leonard, C. L.: Personal communication. 10. Steinberg, C. L.: Personal communication.

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Science for the World's Well-Being

but he almost invariably misses. Of course, he gets the toy anyway as an unearned souvenir of the occasion.

It's Worth the Trouble

Does such a procedure require too much of a busy doctor's time? Not nearly so much as would be required to hold a struggling, shrieking child on the table—with the risk of breaking off the needle in the process. Besides, the little patient becomes a *cooperative* patient, since he learns to anticipate return visits to the doctor's office instead of dreading them. END


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(and all night, too!)
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Stop Useless Debilitating Cough e

Acute respiratory infections
Chronic sinusitis
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Cardiac decompensation
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Pulmonary TB with cold
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2 oz. TUSSIONEX® liquid . . . or 12 TUSSIONEX® tablets . . . a six day supply

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Over 12,000 Clinical Observations Demonstrate Effectivenes

(1) Chan, Y. T. and Hays, E. E., The American Journal of the Medical Sciences, August 1957;

(2) Townsend, E. H., Jr., The New England Journal of Medicine January 9, 1958;

(3) Case, Lee J. and Frederik, W. S., Annals of Internal Medici July 1938.

Adults:
1 tsp. or tablet q 12 h

Children:
Under 1 year.....¼ teaspoon q 12 h
1-5 years.....½ teaspoon q 12 h
Over 5 years..... 1 teaspoon q 12 h

Each teaspoonful (5c.c.) or tablet Tussionex provides 5 mg. dihydrocodeinone and 10 mg. phenyltoloxamine as resin complexes

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Current efforts to lower fees for the aged will do more harm than good, argues this physician. Here he points out why

'DOCTORS CAN'T BEAT THE FORAND BILL'

BY HAROLD J. PEGGS, M.D.

Why don't we have the courage to admit what we all know? The Forand bill, or something like it, is sure to be voted into law. Sooner or later, there'll be Government health coverage for all elderly recipients of Social Security.

The A.M.A. would have us believe that we can stave off such Federal encroachment on private medicine by offering special Blue Shield contracts to old people with "modest resources or low family income." All over the country, doctors are being asked to accept reduced fees to "help beat the Forand bill." What's more, some are acquiescing.

They're making a gesture that's not only futile but downright dangerous!

In my state—Iowa—we have the dubious honor of being the first to respond to the pressing of the panic button. As of this month, we're offering the aged a Blue Shield service contract with fees so low that some of us won't even have our *costs* covered. In other words, we're ready to pay for the privilege of treating the elderly.

Will this generous gesture have the hoped-for effect? It will *not*. Here's what one labor man says: "The doctors are really picking up the ball and running. The only trouble is, the ball they've got isn't the one that

---

THE AUTHOR, *a Creston (Iowa) radiologist, is secretary of the Judicial Council and a member of the Executive Council of the Iowa State Medical Society. But he writes here as an individual practitioner, not as a spokesman for organized medicine. For a full report on Iowa's new Blue Shield contract for the aged, see "They're Taking a 60% Cut in Fees," page 167.*

the game's being played with."

Our fees account for only about 40 per cent of the cost of an illness. The other 60 per cent goes for such expenses as hospitalization and drugs. So no matter what we do, we can't solve the health-cost problem for America's old people.

Blue Shield can pay us 40 or 60 cents on the dollar—if we're willing to settle for it. But no health plan under the sun can force hospitals to cut their costs. Granted, Blue Cross could write some sort of new contract with co-insurance and deductibles. But no such contract could compete with the total coverage the Government can provide.

Just what, then, will we doctors accomplish by lowering our fees for one segment of the population? To begin with, we *won't* be doing anything at all for most of the aged. Some Blue Shield people frankly admit they don't expect to sell the low-rate coverage to more than 20 per cent of the elderly.

But, more important, we'll identify ourselves with these ridiculously low rates. When the blow falls and the Forand bill

goes into effect, the Government will have a ready-made fee schedule *to its taste, not ours.*

Can't you see the planners pointing their fingers at us in a year or two? They'll say: "Look here, these are the fees you set up for your own Blue Shield contracts. Take 'em and like 'em!"

Even worse, these bizarre fees will rise up to haunt us in other situations. For example, most local welfare departments pay higher fees for the care of indigents than does Iowa's new Blue Shield contract. Do we seriously think the welfare people will be content to pay us, say, 75 cents on the dollar when we're magnanimously accepting much less for patients who aren't even totally indigent?

We've been fed the consoling thought that there are only about 15,000,000 aged Americans—an average of some eighty patients for each privately practicing doctor. "You can afford to take a loss on those few," say some medical men. But that reasoning is unrealistic. We all know that these people need more than average time and attention.

Anyhow, averages are mean-

ingless. For instance, what happens to a geriatrician in Florida or Southern California? Should he be forced to give up his right to make a living? For that matter, almost any family doctor, urologist, or radiologist is bound to feel the pinch of one of those new-style contracts.

Meanwhile, some version of the Forand bill will go sailing through Congress in 1960. It's inevitable, as everyone knows—everyone, apparently, except us doctors.

The hospitals and Blue Cross won't seriously fight it. Both labor and management will be relieved to have the burden of health care for the aged shifted to government. We can hope it might be shifted to local or state government instead of Federal Government. But that's all we can hope.

So why must we stand alone? In the name of common sense, why don't we put aside this quixotic gesture? Nothing doctors can do will solve the problem of the aged. But it isn't too late for us to work toward preserving the rest of private practice. Let's get on with *that* job. END

Tax Benefits of Office-Building Ownership

Continued from 94

Before you decide on a sale-and-leaseback arrangement, remember this fact: At the end of the leaseback period, you no longer have your building as an investment. Here's one way to keep the property in the family, however:

A doctor I'll call Henry Green has transferred his office building to his attorney to hold in trust for slightly more than ten years for the doctor's minor children. The doctor pays the trustee a reasonable rent for his own office; and the total income from the property is taxed to the children (they're in a very low tax bracket, of course). Since the net rental totals $3,000 a year, and since Dr. Green has a taxable income of $25,000, he's saving about $1,190 a year in income taxes.

To sum up: If you're considering the purchase of a medical office building, don't look upon taxes as the whole story. But if you handle the situation shrewdly, it can mean real savings for you. END

Exposing Plaintiffs' Attorneys' Tricks

Continued from 90

counsel, a woman testified she'd been unable to walk without help ever since an alleged fall in the doctor-defendant's office. Since she'd been a waitress before the accident, and since she claimed to have earned $128 a week, including her tips, she demanded whopping damages.

But the Philadelphia lawyer subpoenaed copies of her income tax returns—and was thus able to reveal in court that the most she'd ever reported to the Government was $1,100 a year. Comments Harry LaBrum:

"This evidence not only destroyed the plaintiff's claim for damages, but it also cast considerable doubt on her testimony as to the extent of her injuries. The case was settled out of court for only a fraction of the amount previously offered by the insurance carrier."

The fact is, says LaBrum, the subpoena of copies of income tax returns is "one of the most lethal weapons available to defense counsel today."

4. When plaintiffs' attorneys call in a medical expert, the doctors' defenders can sometimes expose him as a "professional plaintiffs' witness."

The plaintiff's whole case often hinges on the testimony of partisan witnesses. There's a "famous story," says LaBrum, about a woman who complained in court that her husband often slashed her with a razor. "When was the last time he cut you?" asked the judge. "Just yesterday he cut me all up, on the face, arms, and everywhere," she replied. And when the judge argued that he could see no bandages nor other evidence of recent wounds, the woman answered: "Judge, what do I want with bandages when I got *witnesses*?"

Pinning this down to doctors, LaBrum says: "All too frequently the defense attorney is confronted with so-called medical experts who permit themselves to be used as accessories in . . . claims of questionable merit. This unholy alliance between some plaintiffs' lawyers and some doctors results in exaggerated claims and padded doctor bills."

More▶

But there's one good way to cope with such witnesses: "Defense lawyers simply have to know the doctors who testify frequently. You have to know what kind of doctor the plaintiff's man is. The little daughter of one of my associates once was asked what kind of doctor her classmate's father was. Here's what she said: 'If a man is going to jump off the Empire State Building, he goes to see Maureen's father first.'

"I say that if a witness is the kind of doctor a plaintiff goes to see first, before he decides what aches and pains he has, defense counsel should know about it and be prepared."

In Philadelphia, he adds, an organization of lawyers called the Defense Counsel Association keeps a watchful eye on the regular medical "testifiers." "All information on each such doctor is collected and made available to other members of the association, so that when that doctor goes into his spiel the next time, counsel is ready for him," explains Attorney LaBrum.

Such preparation pays off. In one recent case, it tripped up a doctor who'd been testifying regularly that plaintiffs would surely have to undergo surgery because of accidents. With this background in mind, the defense counsel forced the doctor to admit on the stand that not one of these prior claimants had in fact ever been operated on. As a result, says LaBrum, "the association effectively removed this dishonest doctor from the scene."

5. When plaintiffs' attorneys quote from medical records, the doctors' defenders can often show they haven't quoted something important.

"A good defense lawyer always makes a thorough investigation of the hospital record, the doctor's records, the nurse's notes, and the drug chart," says Harry LaBrum. Thus, he knows whether the plaintiff's claims are well founded.

In a recent New York case in which records figured prominently, the doctor's defense turned on convincing the jury that the patient had long been seriously ill in the hospital *before* the alleged act of negligence. The doctor concluded his testimony with these words: "In fact, the patient never had a good day during six or seven months."

"Never a good day?" queried the plaintiff's attorney. Trium-

phantly, he referred to the hospital record. "Then how do you explain this entry of 'very good'?" he thundered.

But the defense was prepared for just such a gambit. The doctor's reply: "If you read the nurse's entry correctly, you'll see that the nurse wrote simply that the patient had a *very good enema* that day."

The plaintiff lost his case.

In summing up, J. Harry LaBrum says: "I do not, of course, intend to intimate that all plaintiffs' cases are built-up or that all plaintiffs' lawyers will go to any extreme to win every case. In many cases there is a real question of liability that has to be tried. But more often the only question is 'how much?'

"So the defense counsel must divert the attention of the jurors from the sympathy-getters . . . He must focus the jurors' attention upon the primary issue—the question of whether the defendant is liable. [He must] quietly tell the jury exactly what the plaintiff's attorney is trying to do, explain the tactic, make it clear that it is a tactic."

In the last analysis, then, the defense attorney's best weapons are objectivity and truth. Happily for doctors, those weapons are pretty hard to beat. END

anorectal comfort in minutes

Anusol®

Hemorrhoidal Suppositories and Unguent

Anusol®-HC

dependable Anusol Suppositories with hydrocortisone

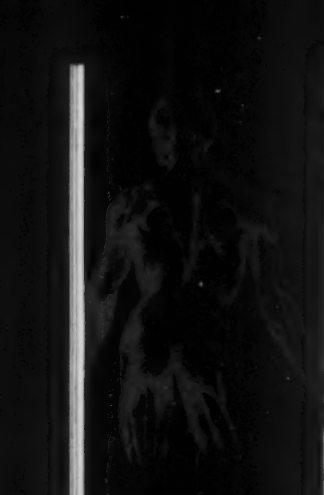
provide full symptomatic control in hemorrhoids, proctitis, pruritus ani

1. Reduce and eliminate all inflammatory symptoms at the outset with new Anusol-HC. Two suppositories daily for 3 to 6 days.

2. Maintain freedom from pain, itching and discomfort with time-proven Anusol. One suppository morning and evening and after each bowel movement. Supplement with Anusol Unguent as required.

Anusol and Anusol-HC contain no narcotic nor analgesic drugs, will not mask symptoms of serious anorectal pathology.

WARNER CHILCOTT



"EXCELLENT,"[3] "MARKED,"[1] "PRONOUNCED,"[2] "SIGNIFICANT"[4] or "GRATIFYING"[5] results in 80.3% of cases of acute skeletal muscle spasm, and "moderate" results in 14.1%—or an over-all beneficial result in 94.4% of cases. Relatively free of adverse side effects.[1,2,4,5]

Now—
in acute skeletal muscle spasm—
A SPEEDIER RETURN

1 **In 33 adults with skeletal muscle spasm secondary to acute trauma:**

"All patients of this group received some degree of relief from the drug, and it is interesting that there was a significant degree of reduction in skeletal muscle spasm in 96% of these patients."[1]

2 **In 39 patients with herniated lumbar and cervical disc, who received methocarbamol for relief of pain and muscle spasm:**

"The response was judged to be pronounced in 25" ... "moderate" in 13. "In most instances the attacks subsided quickly, so that the patients could continue to work or go back to work sooner than expected."[2]

3 **In 17 patients with acute muscle spasm:**

"An excellent result, after methocarbamol administration, was obtained in all patients with acute skeletal muscle spasm."[3]

4 **In 30 patients with pyramidal tract and acute myalgic disorders:**

"Use of this drug (Robaxin) resulted in significant improvement in 27 (90%), questionable improvement in 2, and none in 1 ... No side-effects developed after 72 hours on the medication."[4]

5 **In 60 industrial workers with uncomplicated skeletal muscle spasm:**

"Results were gratifying in that 55 workers, or 92%, could return to full or light duty. No side effects were encountered."[5]

Supply: ROBAXIN Tablets, 0.5 Gm., in bottles of 50.

References: 1. Carpenter, E. B.: Southern M.J. 51:627, 1958. 2. Forsyth, H. F.: J.A.M.A. 167:103, 1958. 3. O'Doherty, D. S., and Shields, C. D.: J.A.M.A. 167:100, 1958. 4. Park, H. W.: J.A.M.A. 167:108, 1958. 5. Plumb, C. S.: Journal-Lancet 78:531, 1958.

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..to assure
maximum safe analgesia

Pain relief—tailored to patient need—even (in many cases) eliminating the need for morphine, "the drug of last resort,"[2] through—

- **Four convenient PHENAPHEN potencies**
  — **for individual selection, to match the intensity of pain**
- **Flexibility of dosage**
  — **for easy adjustment (1 or 2 capsules, as needed) to cope with variations in the level of pain**

ADVANTAGEOUS COMBINATION

"Combinations of codeine with mild analgesic agents are commonly used to relieve pain refractory to the mild analgesic agent alone. Such combinations offer the advantage that pain relief may be afforded by doses of codeine that are ineffective when given alone."[1]

DOSAGE — One or 2 capsules as required.

SUPPLY — Bottles of 100 and 500 capsules.

1. Green, E. G., and Keasling, H. H.: Postgrad. Med. 24:235, 1958.
2. Ritchie, W. P.: J.-Lancet 76:147, 1956.

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PHENAPHEN
Basic non-narcotic formula

Acetylsalicylic acid (2½ gr.)	162 mg.
Phenacetin (3 gr.)	194 mg.
Phenobarbital (¼ gr.)	16.2 mg.
Hyoscyamine sulfate	0.031 mg.

PHENAPHEN No. 2
(Phenaphen with Codeine Phosphate ¼ gr. [16.2 mg.]).

PHENAPHEN No. 3
(Phenaphen with Codeine Phosphate ½ gr. [32.4 mg.]).

PHENAPHEN No. 4
(Phenaphen with Codeine Phosphate 1 gr. [64.8 mg.]).

PHENAPHEN

PHENAPHEN WITH CODEINE

How Good Is Your After-Hours Coverage?

Continued from 86

exactly eager to see him, he may begin to distrust doctors as a species.

If just *one* doctor is made responsible, he'll either handle the case himself or find somebody who can. And this, I think, is a big reason why many men find it so satisfactory to make permanent arrangements for reciprocal coverage with one colleague.

4. The covering doctor is sometimes the wrong choice.

I often wonder how a doctor can enjoy an evening out if he isn't sure a colleague is caring for his patients much as he himself would. Yet some physicians seem to consider *willingness* to cover as the sole qualification the other man needs.

In my observation, the happiest covering arrangements are those made between men in the same field, or at least in closely related ones. Then the substitute has the same sort of hospital privileges and he's able to handle any emergency that's likely to arise.

What if a patient may need special treatment that your substitute isn't qualified to give? Then it pays to line up a specialist for the covering man to call on if necessary. A G.P. I know is always covered by another G.P. except for OB cases; he arranges with an OB/Gyn. man to handle these.

While thinking about your substitute's skills, take his *attitude* into account too. I've seen covering doctors behave with wonderful indiscretion. I know one man who, while covering, loaded his kids in the station wagon and blithely took them for a swim in a lake twenty miles away.

I've known others who've covered while out on the golf course. Sure, they could be reached fairly fast by phone and messenger. But some patients, on learning that the doctor's playing golf, are reluctant to interrupt his recreation. They prefer to wait and suffer, or to try to get help from someone else. In any event, they feel pretty miffed at both the covering man and their regular doctor.

You can be hurt, too, if your substitute gets a substitute without saying anything to you. A cardiologist-friend of mine once asked another cardiologist to

Picture of health—no "angina problem"

(2 years post-infarct)

...on Metamine Sustained, b.i.d.[1]

When anginal episodes persist in spite of E.C.G. evidence of "good recovery" from myocardial infarction, METAMINE SUSTAINED provides ideal protective medication. In fact, METAMINE SUSTAINED protects many patients refractory to other cardiac nitrates,[2] reducing the number and severity of anginal attacks, or eliminating them entirely. Dosage is easy to remember: "1 tablet on arising, and 1 before the evening meal."

Each tablet of METAMINE SUSTAINED slowly releases 10 mg. of aminotrate phosphate (LEEMING), the long-acting coronary vasodilator virtually free of nitrate side effects (nausea, headache, hypotension).[2] And, when you prescribe METAMINE SUSTAINED your angina patient will need less nitroglycerin and thus remain fully responsive to that vital emergency medication.

Supplied: bottles of 50 and 500 sustained-release tablets. Also; METAMINE (2 mg.); METAMINE (2 mg.) WITH BUTABARBITAL (¼ gr.); METAMINE (10 mg.) WITH BUTABARBITAL (¾ gr.) SUSTAINED; METAMINE (10 mg.) SUSTAINED WITH RESERPINE (0.1 mg.).

Thos. Leeming & Co. Inc. 155 E. 44th St., New York 17, N.Y.

1. Elsfelder, H.W.: Case history 4/35. Pers. comm. 2. Fuller, H.L. and Kassel, L.E.: Antibiotic Med. & Clin. Therapy, 3:322, 1956

take over for a few days. The second man agreed. But he later switched week-ends with a third man who was a gastroenterologist. He did this without bothering to tell the physician who'd left a cardiac arrhythmia case in his care.

When this came to light, the first doctor blew his top. Since then, he has made coverage arrangements only with men who seem well qualified in *all* respects, including sound judgment. Which seems very sound judgment on his part.

What about residents as covering men? They may be happy to earn a few extra dollars. But in many hospitals, the rules don't allow them any outside practice. And elsewhere, residents generally have as full a schedule as they can properly handle. So it may well be an all-around disservice to call on them to cover for you.

5. The covering doctor isn't always properly briefed.

I know a woman who went into labor while her doctor was away. Unhappily, the doctor had neglected to tell his covering colleague that the patient had been

promised general anesthesia. Nothing was wrong with the delivery, except that the promise wasn't kept. Result: a successful suit for breach of contract against the absent doctor.

According to most of my colleagues, inadequate briefing is a common problem. When nurses change shifts, there's a formal changing of the guard. But doctors? Sometimes there's little more than a figurative wave good-by.

One doctor calls another: "Jim, I'd like to take off day after tomorrow. You cover for me, and I'll cover for you next Monday. O.K.? O.K." And that's it.

A Better Way

Yet it takes only a few minutes for the departing doctor to sit down with a dictating machine, go over his day book for the preceding two weeks, and pinpoint possible problems for the covering man. A brief explanation of why you handled a given patient in a given way may help too. It may also keep the covering doctor from stating a diagnosis or prognosis substantially different from yours—a fine way to undermine the patient's confidence in both men.

I've tried this system of briefing a covering doctor. And I find

that only about 20 per cent of the patients' problems I mention ever arise for the covering man. But even this makes the dictation well worth doing, seems to me. It's better than having the unmentioned special situation present itself as soon as you've driven off for the week-end.

But, though the absent man may have told his cover all about the problems that may arise in current cases, the majority of problems may well be with patients not seen recently. Therefore, one of the worst sins a departing doctor can commit is to leave his records locked away beyond reach of the covering man.

What if, for example, the covering man is called to see a patient with abdominal distress and finds the abdomen criss-crossed with surgical scars? It would be useful, to say the least, for him to be able to get into the files quickly to see just what organs have been removed. Many otherwise knotty clinical problems are easily solved when the office records are available. When they're not, things can be rough.

Incidentally, if you're a specialist, don't forget to tell the covering man about hospital patients you've seen in consultation. One night, when I was covering for another internist, I got an angry call from a surgeon about a case of G.I. bleeding, pulmonary emphysema, and CO_2 narcosis. Though my week-ending colleague had been following the case as a consultant, this was the first I'd heard of it. I could—and should—have handled the problem on that morning's rounds.

6. Too often there's confusion about fees.

In most covering arrangements, the covering man bills the

IN CASE YOU'RE DELAYED

One doctor I know has his receptionist note the arrival time of each patient. This is conveyed to him on a slip attached to the patient's medical record. If there's any delay in seeing the patient, the doctor apologizes for the delay and explains the reason. Smart public relations, I call it. —JOHN R. SEDGWICK

patient for any services rendered. This seems to work all right—as long as both men have similar fee schedules.

But what if they don't? Suppose Dr. Fraser does an emergency appendectomy on one of absent Dr. Hunt's patients and then bills her for $175. If she knows that Dr. Hunt charges only $125 for such services, she may be displeased with both men.

Or suppose Dr. Fraser bills her for only $100. Then she may suspect her own doctor of charging her exorbitant fees.

Rx for Billing

To eliminate this problem entirely, some covering arrangements provide that the patient's own doctor will do all the billing and will pay the covering man for services performed. Other doctors agree between themselves to use the absent doctor's fee schedule, even though the substitute doctor bills and collects.

Under any such arrangement, OB fees usually have to be prorated. They usually cover pre- and post-natal care as well as the delivery itself, and the substitute gets only that portion he's entitled to. Better come to an agreement on this in advance if you want to avoid confusion.

One way to guarantee confusion is to leave it up to the patient to decide who gets paid. This method is used by one young G.P. I know. He regularly covers for five other doctors, and he always asks the patient: "Would you rather pay me or pay your regular doctor?" If the patient wants to pay his regular doctor, the latter pays the G.P. his fee—whether or not the regular doctor actually collects from the patient. The bookkeeping problems are fierce.

There's a system used by some men that avoids *all* fee problems: a perpetual coverage agreement that the absent man will always bill his own patients, and retain the fees, for services rendered by his colleague. Doctors who swear by this system say they come out even over the years.

And that ends my list of after-hours coverage kinks and what can be done about them. They're little things, most of them. But they can cause vast damage.

Chances are they haven't yet in your case, I suppose. But with the stakes so high, why trust to luck? END

Don't Overlook Convertible Bonds

Continued from 77

ments to stockholders. Primarily because interest payments on bonds are tax-deductible for a company, they can prove less costly than dividends.

Finally, there are three terms used in connection with convertible bonds that you'll want to understand before you consider buying a given issue: its *investment value*, its *call price*, and its *conversion value*.

When a financial expert mentions a convertible's "investment value," he's merely referring to the price it should sell at if it's to yield roughly the same amount of interest as regular bonds of comparable quality. To put it another way, he's thinking of its value as a straight bond, apart from its value as a bond that can be converted into stock.

When he speaks of its "call price," he means the price that the company would pay if it exercised its right to redeem the bond before its maturity date. Almost without exception, companies that issue convertibles retain a right to call in the bonds at a slightly higher price than their face value. For instance, Thompson's convertibles have a face value of 100 ($1,000). But if the company redeems them before their 1982 maturity date, it will pay 104.625 ($1,046.25).

Why would a company want to call in its bonds before maturity? Well, for one thing, it may have issued the bonds merely as an inexpensive way of selling common stock. So if the bonds start selling for much more than their call price, the company can call them in—thus forcing their owners to convert them in order to avoid losing their profit. Or else the company may feel it's now in a position to finance its operations more cheaply. Last year, for example, Smith-Corona unexpectedly called in all its convertibles paying 6 per cent interest. It then issued new bonds paying only 5¼ per cent.

The third term your financial adviser may use is "conversion value." As we saw in the case of Brunswick-Balke's convertibles, this represents the current price of the company's common stock multiplied by the number of shares of stock into which one bond may be converted.

Only in very special cases will a convertible sell *below* its con-

pyelonephritis

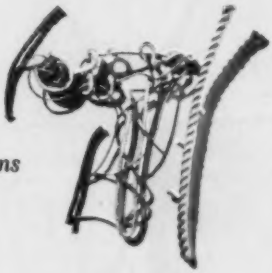
"the most important concept is that it is a tubular disease"[1]

FURADANTIN®

brand of nitrofurantoin

a most important characteristic: effective at the tubular level

in each patient:
2 million reasons
for using
FURADANTIN first



In addition to simple glomerular filtration, FURADANTIN is actively excreted by the cells of the tubules. A significant and singular characteristic of FURADANTIN, it is but one reason why "the protracted administration of nitrofurantoin [FURADANTIN] to patients with ineradicable urinary tract infection, particularly chronic pyelonephritis without demonstrable obstruction, may usefully complement the medical management of this difficult problem."[2]

Available as Tablets, 50 and 100 mg.; Oral Suspension, 25 mg. per 5 cc. tsp.

References: 1. Smith, I. M., and Lenyo, L.: Am. Practitioner **9**:78, 1958. 2. Jawetz, E., et al.: A.M.A. Arch. Int. M. **100**:549, 1957.

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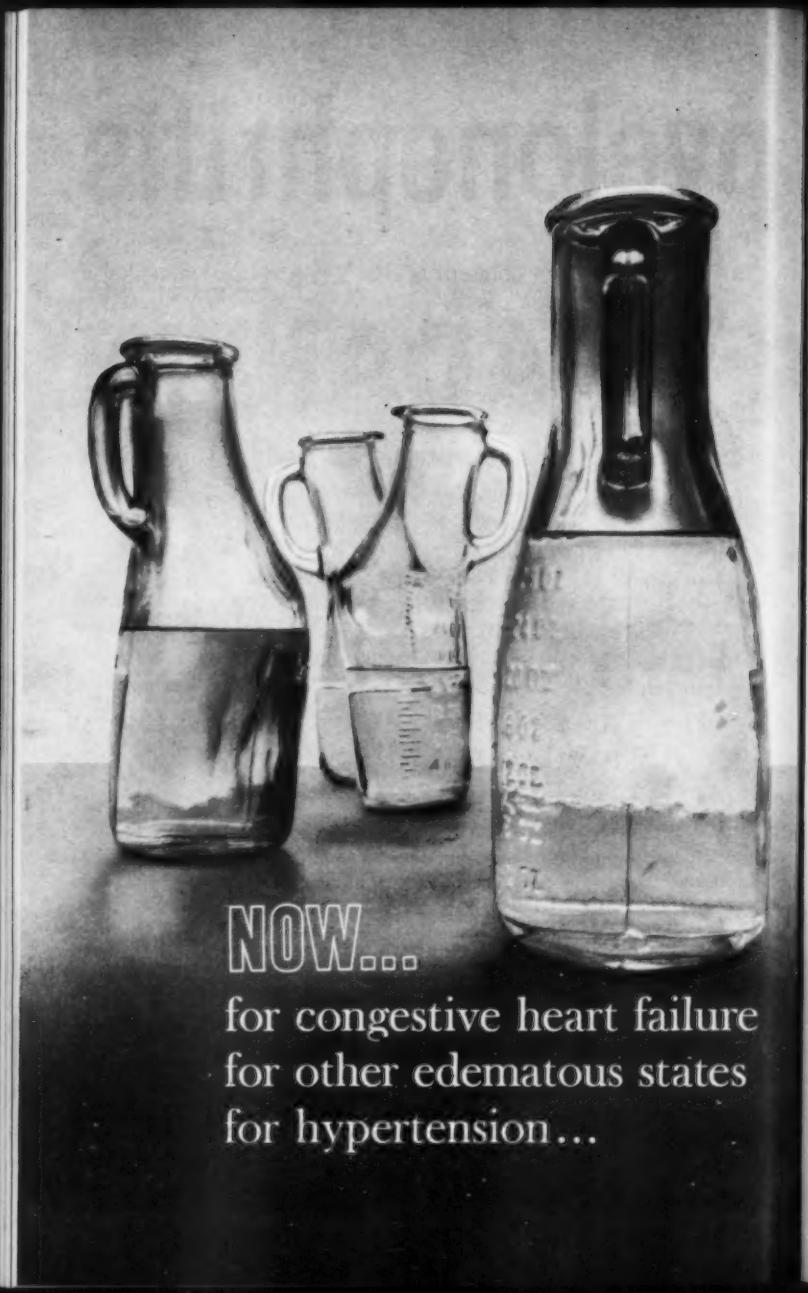
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for congestive heart failure
for other edematous states
for hypertension...

Clinical data ▶

highest fluid yields,
lowest blood pressure levels
yet achieved with oral
diuretic-antihypertensive
therapy...

Esidrix™

(hydrochlorothiazide CIBA)

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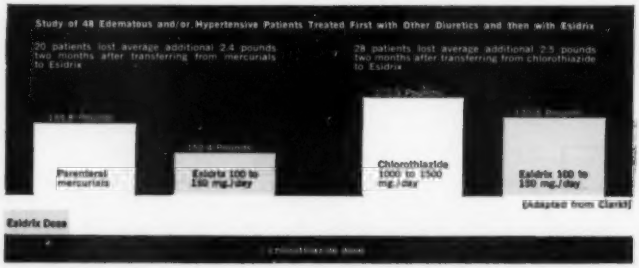
Esidrix: 10 to 15 times more active than chlorothiazide in edema and hypertension

Esidrix relieves edema in many patients refractory to other diuretics: Studies reveal that certain patients unresponsive or refractory to mercurials and chlorothiazide respond readily to Esidrix. Brest and Likoff[1] observed that 9 of 12 patients with congestive heart failure – who failed to respond to other diuretics – were completely controlled with Esidrix. Esidrix appears to have clinical value even after the patient has developed partial tolerance to chlorothiazide, and may be found useful in cases of sensitivity to chlorothiazide.[2]

Therapy with Esidrix often results in more weight loss than with other diuretics: In a study[3] of 48 patients with edema and/or hypertension, who were treated originally with chlorothiazide or with mercurial diuretics, substitution of Esidrix at a dose of 100 to 150 mg./day resulted in additional average weight loss of 2.4 to 2.5 pounds.



DOSAGE: Esidrix is administered orally in an average dose of 75 to 100 mg. daily, with a range of 25 to 200 mg. A single dose may be given in the morning or tablets may be administered 2 or 3 times a day. SUPPLIED: *Tablets*, 25 mg. (pink, scored); *Tablets*, 50 mg. (yellow, scored).

REFERENCES:
J. Brest, A. N., and Likoff, W.: Am. J. Cardiol. *3*:144 (Feb.) 1959. 2. Esch, A. F., Wilson, I. M., and Freis, E. D.: M. Ann. District of Columbia *28*:9 (Jan.) 1959. 3. Clark, G. M.: Clinical report to CIBA. 4. Dennis, E. W.: Clinical report to CIBA. 5. Hejtmancik, M. R., Herrmann, G. R., and Kroetz, F. W.: In press. [A preliminary report by these investigators has been published in Texas J. Med. *54*:854 (Dec.) 1958.]

CIBA
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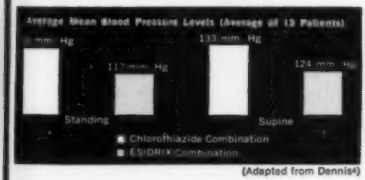
Esidrix™

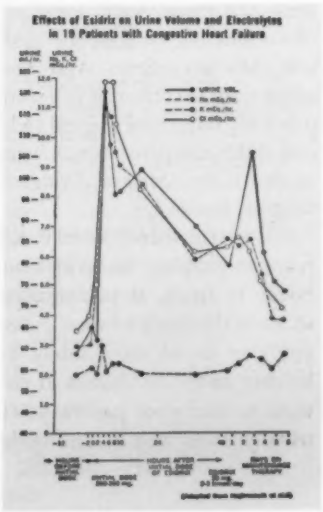
(hydrochlorothiazide CIBA)

Produces greater average reduction in blood pressure: Eleven of 13 hypertensive patients[4] were treated initially with a chlorothiazide-mecamylamine-reserpine combination (10 patients had 1000 mg. and 1 patient 500 mg. chlorothiazide daily); 1 patient had been treated with hydralazine and 1 had no previous medication. Nine were then transferred to an Esidrix-mecamylamine-reserpine combination and 4 to an Esidrix-reserpine combination for periods of 3 to 7 weeks (12 patients had 100 mg. and 1 patient 50 mg. Esidrix daily). Average mean blood pressure levels were recorded in the standing and supine positions. As shown in the graph below, there was a further drop in blood pressure after patients were transferred to Esidrix.



(Adapted from Dennis[4])

Exceptional safety... reduced likelihood of electrolyte imbalance: While Esidrix markedly increases sodium and chloride excretion, it has far less effect on excretion of potassium (see chart at right) and bicarbonate. Hence, there is little likelihood of disturbing electrolyte balance when recommended procedures are followed.



version value. But it may well sell *above* it if the corresponding common stock shows exceptional promise.

As we've seen, the number of stock shares into which you can convert a bond at a given period is fixed in advance. There's no problem in converting; your broker will do the job for you routinely. Your only problem, once you own a convertible, is this: When, if ever, should you convert?

Generally speaking, there are only two times when you'd probably do so. You'd *have* to convert (or lose money) if the issuing company called in the bonds while they were selling above their call price. Such early redemptions may not be the rule, but they do occur. And you might *want* to convert if you were primarily interested in good yield and if the company's stock were paying better current dividends than the bonds.

Otherwise, there's never much point in making the shift from bonds to stock. If you want to share in the stock's future gains, you can do so most safely by holding on to your bonds. If you want to take your profits, you'll usually do as well by selling the bonds directly as by converting them into stock first.

And so we return to our first question: What's a *good* convertible?

How to Evaluate Them

A partial answer: A convertible bond is only as good as the company that issues it. Especially in a bull market, there are apt to be quite a few questionable offerings. It's fairly common practice for second-line companies to take advantage of investor optimism by making their bond issues convertible. It's somewhat less common for well-known concerns to issue convertibles, although an increasing number have done so recently.

Furthermore, the really solid offerings are likely to be well publicized just because they are so solid. As a result, they're often high-priced. And when the price of a convertible rises above a certain point, the issue is no longer a particularly good buy.

In almost any kind of market, however, you'll usually find some good bets. Here are five tested rules for spotting them:

1. Consider a convertible bond promising if the issuing company has earnings large enough to cov-

NOW... AROUND-THE-CLOCK CONTROL OF APPETITE

NEW PRELUDIN® ENDURETS™

A PROLONGED-ACTION DOSAGE FORM

Clinical experience has long established PRELUDIN as an antiobesity agent distinguished by its efficacy and its relative freedom from undesirable side actions. Now, convenience is added to reliability in ENDURETS... a specially devised long-acting pharmaceutical form.

Just one PRELUDIN ENDURET (75 mg.) tablet after breakfast curbs appetite throughout the day, in the vast majority of cases.

PRELUDIN® (brand of phenmetrazine hydrochloride) ENDURETS™.
Each ENDURET prolonged-action tablet contains 75 mg. of active principle.
PRELUDIN® is also available as scored, square, pink tablets of 25 mg. for 2 to 3 times daily administration.
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er all its obligations, even if there were a recession. One good question to ask: Over a period of years, have the company's net earnings been several times the amount that it has had to pay out in interest on bonds?

Check the Common Stock

2. Consider a convertible bond promising only if the company's common stock seems equally promising. As we've seen, bond prices don't usually tumble as far as stock prices. But many investors have lost money on convertibles because they overrated the related common stock.

3. Be wary of a convertible whose common stock is now selling at or near its all-time high. For the time being, at least, both stock and convertible may have exhausted their ability to rise.

4. Be wary, too, of a convertible that's already selling greatly in excess of its investment value. A good issue will probably sell for more simply because of its convertible feature. But you'll be wise if you try to find one that has risen no more than twenty or so points above its investment value. A bond that sells for considerably more might fall very sharply in a bear market.

5. Keep an eye on the conversion value. If a given issue sells well above its conversion value, better ask yourself whether the company's common stock may not be a better buy simply because it's less expensive.

Where conversion value is concerned, remember that you stand to lose money if the company calls in an overpriced issue. For example, when Smith-Corona called in its convertibles, they had a conversion value of about 117. But they were actually selling around 125. Naturally, they tumbled right back to 117 —their real worth in terms of the stock into which bondholders were forced to convert them in order to avoid redemption at the call price of 105¾. Although he saved money by converting, the investor who'd bought six of them at, say, 124 still lost nearly $500.

So seasoned investors agree that the ideal convertible sells not much above its investment value and at or near its conversion value. Very few issues meet both these tests. Once you've found a bond that does, it's likely to be a very good buy if the issuing company is also a very good company. END

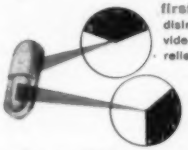
control congestion ⇄ control cough

Control of respiratory congestion is basic to breaking the cough-congestion cycle.
Through the superior decongestant action of the Triaminic in this formula, irritating postnasal discharge is reduced. This relieves the sensitive laryngeal and pharyngeal membranes—"trigger" areas of the cough reflex.

Control of cough through the reflex center interrupts self-perpetuation of the cycle.
The non-narcotic antitussive action of Dormethan is as effective as that of codeine but is free of codeine's narcotizing and constipating side effects. In addition, Dormethan acts quickly.

The classic expectorant property of terpin hydrate thins inspissated mucous secretions.
This makes it easier for the patient to clear the respiratory passages of annoying mucus. It is also useful to help overcome the morning hacking found in chronic postnasal drip.

The "timed release" design of Tussaminic Tablets provides effective relief from cough within minutes, lasting 6 to 8 hours.



Each TUSSAMINIC* *timed-release tablet provides:*

TRIAMINIC® (Phenylpropanolamine HCl, 50 mg.; phenirannine maleate, 25 mg.; pyrilamine maleate, 25 mg.)	100 mg.
Dormethan (brand of dextromethorphan HBr)	30 mg.
Terpin hydrate	300 mg.

Dosage: One tablet in the morning, midafternoon and in the evening, if necessary.

Tussaminic® *timed-release tablets*

**Contains* TRIAMINIC *to* STOP *running noses* *and open stuffed noses orally*

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska • Peterborough, Canada

Holes in Your Life Insurance Program?

Continued from 72

that, because of his occupation, he'd had to pay an extra $5 for every $1,000 worth of insurance.

Of course, the rating should have been lifted when the doctor had quit the job. But he had neglected to notify the company of the change. Now he has done so, and the company has paid him a refund of $1,500. If the mistake had never been discovered, the money would have been lost forever.

Similarly, if you've been rated up for health reasons, you'll do well to ask the company to give you another physical exam now. The insurance industry is much more liberal about ratings than it used to be. Even if your health hasn't improved, there's a chance your rating may be lowered.

You can't lose by being re-examined. Regardless of its findings, the carrier can't legally *raise* your premium. *More*▶

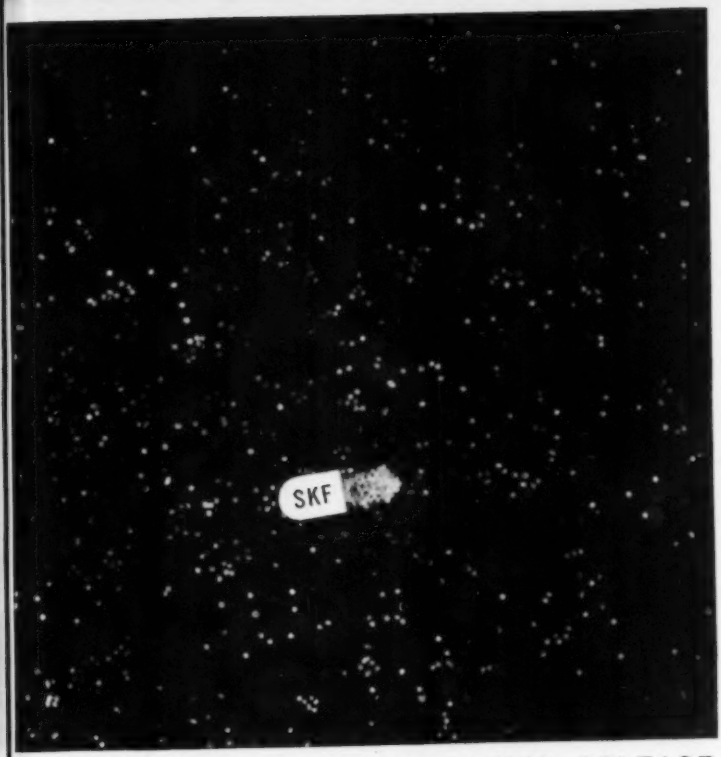
BEST BUSINESS BAROMETER

If you want to estimate whether your own earnings will be higher or lower six months from now, try asking a few dentists, "How's business?"

Bernard Baruch once called dental practices "the best general economic indicator of all." The reason, of course, is that dentistry is widely regarded as an optional service. People do without dental care when they're hard up for funds. When economic conditions improve, dentists may be the first ones to know it.

Proof of this theory came during the business upturn last year. Politicians were still bewailing the apparent recession; some physicians were still reporting a collections lag. But many dentists suddenly noticed that their receipts had begun to climb. And, sure enough, the nation's economy eventually followed.

Right now, dental receipts are booming. But you'd better take another reading—perhaps toward the end of the year—before making your income estimates for 1960. END



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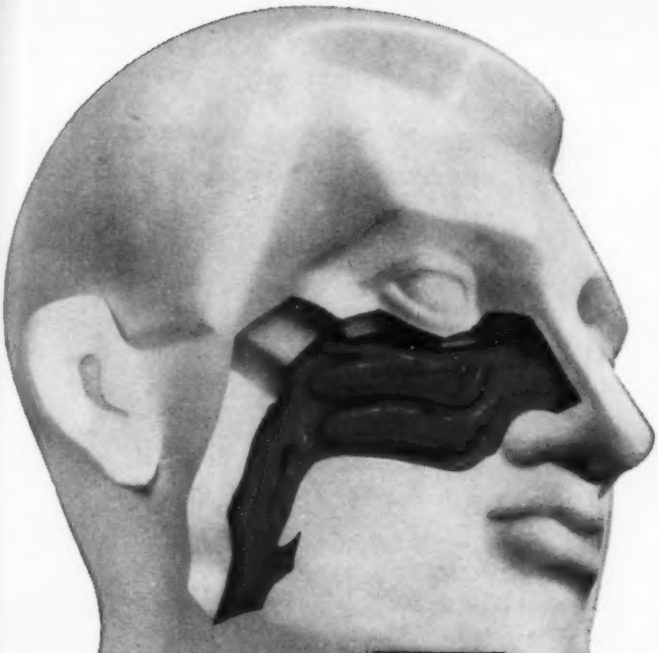
8. What about your insurance dividends?

If you're insured with a mutual company, you've had the choice of either leaving dividends with the company or deducting them from annual premium payments. Chances are, at least some of your dividends have been piling up. Such money can be a valuable asset if you handle it right.

For instance, if your health isn't what it was, you'd probably do well to buy extra life insurance with your dividends. That may be the only way you can get more coverage without having to pay a stepped-up premium or to submit to another physical examination.

Or possibly your total dividend accumulations on some old policy are large enough to pay it up. If you want to use some dividend money in this fashion, you can cut down your annual premium payments without loss of coverage.

In any case, better check into your dividend accumulations. They may be the means by which you can fill some loopholes in your coverage. END



delivers more steroid to the site of inflammation

NASAL SPRAY NEO-HYDELTRASOL®

Prednisolone 21-phosphate with Propadrine®, Phenylephrine® and Neomycin

Only NEO-HYDELTRASOL provides its steroid component in true solution—a definite therapeutic benefit, since in pure solution more of the steroid is immediately available to inflamed nasal mucosa.

The anti-inflammatory action of the prednisolone 21-phosphate is reinforced by two valuable decongestants—for fast and prolonged action—and neomycin to combat intranasal infection.

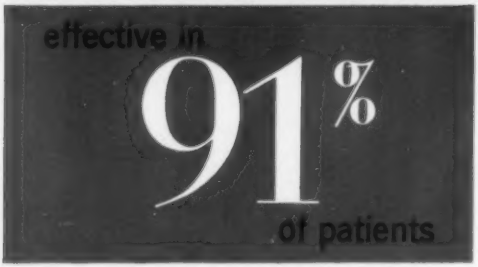
Supplied in 15-cc. plastic spray bottles

NEO-HYDELTRASOL is a trademark of Merck & Co., Inc.

MSD MERCK SHARP & DOHME
Division of Merck & Co., Inc., Philadelphia 1, Pa.

1½ minutes of your time reading about Trancopal may change your prescription habits when treating musculoskeletal and psychogenic disorders.

in musculoskeletal conditions[1]



Low back pain (lumbago)
Bursitis
Osteoarthritis
Fibrositis
Myositis
Postoperative myalgias

Neck pain (torticollis)
Rheumatoid arthritis
Disk syndrome
Joint disorders (ankle sprain, tennis elbow, etc.)

By relieving muscle spasm and pain, Trancopal permits early and active purposeful exercise and physical therapy to accomplish maximal benefits for rapid recovery.

thoroughly evaluated clinically

Clinical studies of 4092 patients by 105 physicians[1] have demonstrated that Trancopal often is effective when other drugs have failed. From these studies it is evident that Trancopal can provide more help for a greater number of tense, spastic, and/or emotionally upset patients than can any other chemotherapeutic agent in current use.

Trancopal®

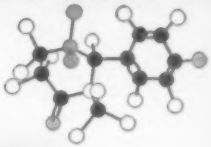
the first true tranquilaxant*

Potent MUSCLE RELAXANT

...Equally effective as a TRANQUILIZER

Chlormezanone: 2-(4-chlorophenyl)-3-methyl-4-metathiazanone-1-dioxide

nrelated chemically to any other drug in current use, rancopal offers a completely new major chemical ntribution to therapeutics.



in anxiety and tension states[1]

effective in

88%

of patients

Anxiety and tension states	Dysmenorrhea
Premenstrual tension	Asthma
Emphysema	Angina pectoris

ecause of its exceptional calmative property, Trancopal "... allows the patient use his energies in a more productive manner in overcoming his basic problem."[2]

better tolerated and safer than older drugs[3]

With Trancopal there is no clouding of consciousness, no euphoria or depression. Even in high dosage, there is no perceptible soporific effect. Because it does not irritate gastric mucosa, it can be taken without regard to mealtimes. Administration does not hamper work — or play. There are no known contraindications. Blood pressure, pulse rate, respiration and digestive processes are unaffected by therapeutic dosage. Toxicity is extremely low. And Trancopal has a lower incidence of side effects than has zoxazolamine, methocarbamol or meprobamate.

Dosage: One Caplet (100 mg.) orally three or four times daily. Relief of symptoms occurs in fifteen to thirty minutes and lasts from four to six hours.

Supplied: Trancopal Caplets® (scored) 100 mg., bottles of 100.

References: 1. Cooperative Study, Department of Medical Research, Winthrop Laboratories. 2. Gans, S.E.: To be published. 3. Lichtman, A.L.: Kentucky Acad. Gen. Pract. J. 4:28, Oct., 1958.

tran'kwi-lak'sant [<L. *tranquillus*, quiet; *laxare*, to loosen, as the muscles]

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New York 18, New York

ancopal (brand of chlormezanone) and Caplets, trademarks reg. U.S. Pat. Off.

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"I seem to have the blues all the time... I can't sleep..."

in the depressed, unhappy patient

PROMPTLY IMPROVES MOOD

without excitation

- **Acts fast to relieve depression and its common symptoms:** sadness, crying, anorexia, listlessness, irritability, rumination, and insomnia.
- **Restores normal sleep**—without hang-over or depressive aftereffects. Usually eliminates need for sedative-hypnotics.

Composition: Each light-pink, scored tablet contains 1 mg. benactyzine HCl and 400 mg. meprobamate.

Dosage: 1 tablet q.i.d.

'Deprol'

WALLACE LABORATORIES, *New Brunswick, N. J.*

Memo

From the Editors

Coming in May

"What! Another survey?"

That's likely to be the first reaction of a doctor whose morning mail brings him a questionnaire to fill out. But if he sees a real chance to help himself, he'll generally reply.

A case in point is the reaction by doctors to a questionnaire sent out recently by MEDICAL ECONOMICS. It was four pages long and ran to ninety-four questions. Despite its length, it was completed and returned by nearly 55 per cent of the doctors who received it. Such a response is considered high by any standard of scientific sampling. Coupled with the cross-sectional nature of the survey, it means you can count on the general validity of the results.

In this case, the topic of investigation was office-visit fees. To see the results, look for the articles featured on the covers of the two May issues of this magazine. They'll answer these questions:

¶ How much are doctors now charging for office visits? The May 11 article will give you a basis for comparing your fees with others'. For example, how do fees in your field of practice and area differ for a routine office visit, an initial visit, a follow-up visit, an annual check-up?

¶ Which services do doctors charge extra for, and which do they include as part of a routine office visit? The May 25 article will report how physicians decide about charging for fifty different office procedures.

The only way to get answers to such practice-connected questions is through you and your colleagues. That's why this magazine is always surveying doctors. What you tell us becomes the backbone of articles that you wouldn't want to miss.

Right now, for example, preparations are under way for MEDICAL ECONOMICS' 9th Quadrennial Survey of physicians' earnings. It's planned for early 1960, to cover the year 1959. Meanwhile, more than two dozen smaller surveys are already in the works.

If past surveys are any guide, between 40 and 70 per cent of the doctors surveyed will take the trouble to respond. They usually do so because they realize they're doing themselves a good turn. But they're also doing *you* a good turn. You'll find proof of that fact in our May cover stories. END